



REFERENCE HANDBOOK

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**503 S Kansas Ave.
Topeka, KS 66603
(785) 296-4986
Fax (785) 296-0256
Toll-free (800) 432-3535**

This handbook is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

KDADS does not discriminate on the basis of race, color, national origin, sex, age, or handicap. If you feel that you have been discriminated against, you have the right to file a complaint with KDADS, at 1-800-432-3535 or TDD: 785-291-3167 or 1-800-766-3777.



The SHICK Program is funded by a grant from the U.S. Administration for Community Living (ACL), U.S.

Department of Health and Human Services (DHHS).



Revised April 2018

Responsibilities of the State SHICK Office

- Support Sponsoring Organizations in the recruitment of Counselors and Partners.
- Determine criteria for counselor certifications and re-certification.
- Conduct ongoing education for Counselors, Partners, and Coordinators.
- Supply Sponsoring Organization, Coordinator, and Counselors with information resources.
- Refer clients to Sponsoring Organizations.
- Monitor performance of Sponsoring Organizations, Coordinators, and Counselors to ensure the provisions of the *SHICK Minimum Requirements* are met.
- Provide information to the public regarding SHICK, Medicare, and other health insurance issues.
- Market the SHICK program through coordinated efforts with the Sponsoring Organizations.
- Promote the SHICK program on a statewide basis.
- Manage and assist the SHICK Call Centers.

Responsibilities of the SHICK Sponsoring Organization and the SHICK Coordinator

- Appoint a properly qualified Coordinator of Counselor Activities and a backup in case of absence.
- Monitor performance of Coordinator & local counselors to ensure the *SHIP Minimum Requirements* are met.
- Provide expenditure reports to the Kansas Department for Aging and Disability Services for funds awarded pursuant to the Program Agreement with SHICK.
- Recruit Counselors and Partners in the local area.
- Screen volunteers for suitability as SHICK Counselors (e.g. ensure no conflict of interest exists).
- Ensure that Coordinators and Counselors have fulfilled training requirements, are certified by the SHICK program, and are competent to provide counseling services.
- Work with SHICK program staff and other agencies to coordinate presentations and outreach events.
- Collaborate with community organizations to ensure that low-income and hard-to-reach populations have access to SHICK counseling services.
- Provide speakers for public events as requested.
- Host Initial & Update trainings for local Counselors and Partners.
- Receive client telephone calls & assign to Counselors based on the needs of the client.
- Market the SHICK program through coordinated efforts with the State SHICK Office.
- Serve as a clearinghouse for supplies and materials to Counselors and Clients.
- Provide Counselors access to a copy machine, telephone, and computer with Internet at the Sponsoring Organization for the purposes of counseling Clients.

- Maintain frequent communication with Counselors regarding activities and job performance. This includes disseminating updated information necessary for counseling.
- Complete Client Contact reports and Public and Media reports for each contact or public or media event.
- Enter Client Contact reports and Public and Media Reports on the National STARS data entry system every month by the last day of the following month.
- Provide a monthly calendar of events to the State SHICK Office.
- Participate in SHICK conference calls or meetings as scheduled (teleconference and/or webinar).
- Attend SHICK Update Training each year. (Required each year to maintain Active Counselor status.)
- Read SHICK listserv messages and disseminate information to Counselors & Partners.
- Ensure that all Volunteers are registered on the STARS data entry system.
- Attend other Special Trainings as announced.

Responsibilities of the SHICK Counselor or SHICK Partner*

- Satisfactorily complete certification training.
- Attend SHICK Update Training each year.
- Read and sign the Memorandum of Understanding each year.
- Provide confidential individual health insurance counseling services without conflict of interest and in compliance with *SHIP Security Plan Guidelines* for safeguarding confidential beneficiary information.
- Provide referrals to appropriate resources.
- Maintain frequent communication with their Coordinator.
- Complete Client Contact reports for each contact and Public and Media reports for each public or media event and complete the online reports on STARS.
- Email/internet access is required.
- Subscribe to SHICK listserv and read listserv messages.
- Provide information to the public regarding Medicare and other health insurance issues as outlined in the *SHIP Minimum Requirements*.

Optional:

- Give public presentations
- Help with Health Fairs & Other Events

*The “SHICK PARTNER” is trained and signs the Memorandum of Understanding just as the Volunteer Counselor does. Other SHIP Minimum Requirements apply as well, though the Partner takes this training for use in his or her job (e.g. social worker, case manager, discharge planner).

KDADS Programs

SHICK is a program of the Kansas Department for Aging and Disability Services under the Commission on Aging. It is part of the Medicare Grants Division, which encompasses the following three grant programs funded by a grant from the U.S. Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS).

SHICK

Senior Health Insurance Counseling for Kansas (SHICK) provides free, unbiased, and confidential assistance to Kansans who have questions about Medicare and related insurance issues. SHICK's trained community counselors provide information and assistance with Medicare issues, Medicare claims and appeals, Medicare Prescription Drug Coverage (Part D), Medicare supplemental insurance (Medigap) policies, long-term care financing and options, and other health insurance issues. SHICK counselors also help eligible consumers access the assistance programs offered by pharmaceutical companies to reduce medication costs.

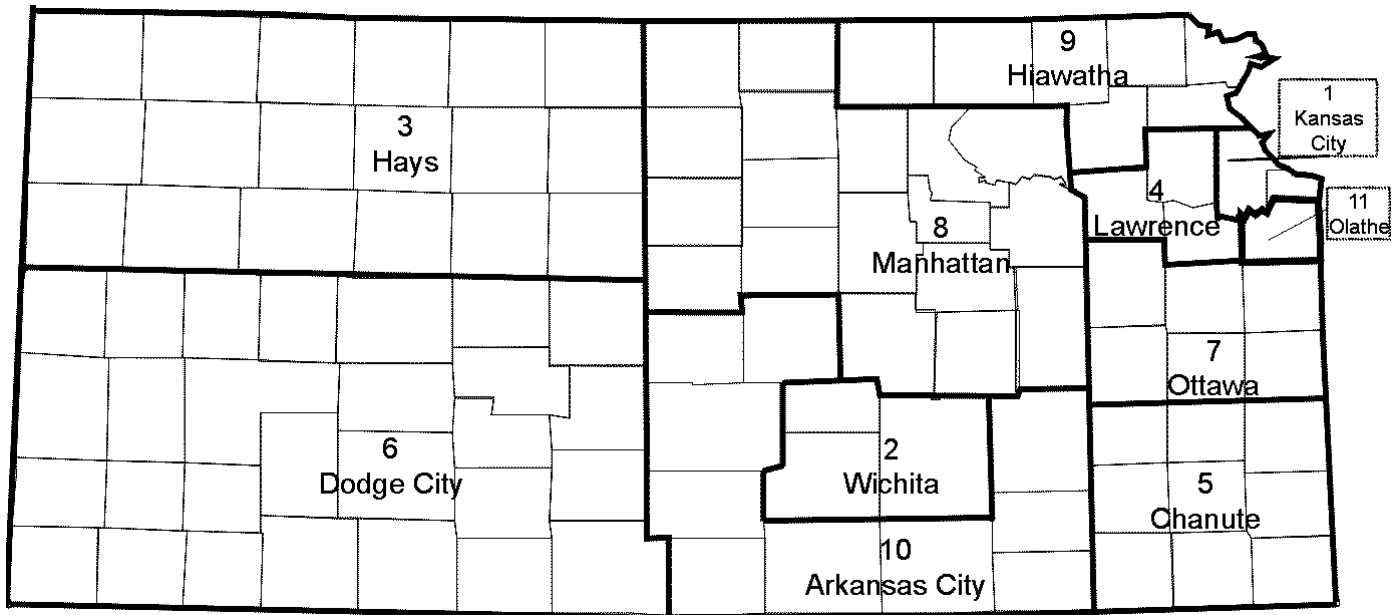
Kansas SMP

The Kansas SMP (Senior Medicare Patrol) project educates Medicare and Medicaid beneficiaries and providers about health care fraud, error, and abuse. Kansas SMP has created a statewide coalition of regulatory agencies, law enforcement officials, and community organizations to help alert the public to potential fraud activities. Trained SMP volunteers provide education, outreach, one-on-one assistance, and problem resolution to beneficiaries, helping them to identify and report health care fraud and abuse.

MIPPA

On July 15, 2008, Congress enacted into law the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Pub. Law 110-275. In 2013, KDADS received a grant to promote outreach and assistance for Medicare beneficiaries eligible for Medicare Part D Extra Help and Medicare Savings Programs. This act also provided funding to promote Medicare Part D counseling and assistance in rural areas, as well as funding to promote preventive services covered by Medicare Part B.

In the state of Kansas in 2015, KDADS contracted with 11 organizations across the state to implement the MIPPA grant, including Area Agencies on Aging, SHICK Sponsoring Organizations, and Adult Disability Resource Centers. These organizations have gone across the state to promote Medicare Part D to rural areas, preventive services, Extra Help, and Medicare savings programs through many venues including health fairs, enrollment events, social media, and media outlets including television and newspapers, as well as providing information to Medicare beneficiaries who come into their office. SHICK trained counselors within these organizations also provide assistance with applications for Medicare Savings Programs and Extra Help.



Area Agencies on Aging

There are 11 Area Agencies on Aging (AAA) in Kansas, each covering a specific geographical area. These agencies coordinate service and programs for persons age 60 and over in each area. The numbers on the above map refer to Area Agencies. Of the 11 AAA's, 10 are SHICK Sponsoring Organizations. Johnson County AAA (11) is not a SHICK sponsoring organization. The SHICK program for Johnson County is coordinated through the East Central Kansas AAA.

SHICK Sponsoring Organizations

Wyandotte/Leavenworth County Area Agency on Aging

913-573-8545 / 1-888-661-1444 / (fax) 913-573-8577

849 N 47th St., Kansas City, Kansas 66102

Counties: Leavenworth, Wyandotte

Sedgwick County Extension & SHICK Call Center

316-660-0100/ ext. 0117 / 316-722-1432 (fax)

7001 W. 21st North, Wichita, KS 67205

County: Butler, Harvey, Sedgwick

Central Plains Area Agency on Aging

316-660-5120 / 800-367-7298 ext. 5132

2622 W. Central Suite 500, Wichita 67203

County: Butler, Harvey, Sedgwick

Northwest Kansas Area Agency on Aging

785-628-8204 / 800-432-7422 / 785-628-6096 (fax)

510 West 29th, Suite B, P O Box 610, Hays, KS 67601

Counties: Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Norton, Osborne, Phillips, Rawlins, Rooks, Russell, Sheridan, Sherman, Smith, Thomas, Trego, Wallace

*Douglas County Senior Services***785-842-0543 / 877-295-3277 / 785-842-0562 (fax)**

745 Vermont, Lawrence, KS 66044

County: Douglas*Jayhawk Area Agency on Aging***785-235-1367 / 800-798-1366 (outside Topeka) / 785-354-5346(fax)**

2910 SW Topeka Boulevard, Topeka, KS 66611

County: Jefferson, Shawnee*Southeast Kansas Area Agency on Aging***620-431-2980 / 800-794-2440 / 620-431-2988 (fax)**

1 West Ash, P. O. Box J, Chanute, KS 66720

County: Allen, Bourbon, Cherokee, Crawford, Labette, Montgomery, Neosho, Wilson, Woodson*Southwest Kansas Area Agency on Aging***620-225-8230 / 800-742-9531 / 620-225-8240 (fax)**

236 San Jose Dr., P. O. Box 1636, Dodge City, KS 67801

County: Barber, Barton, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearny, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Rush, Scott, Seward, Stevens, Stafford, Stanton, Wichita*East Central Kansas Area Agency on Aging***785-242-7200 / 800-633-5621 / 785-242-7202 (fax)**

117 South Main, Ottawa, KS 66067

County: Anderson, Coffey, Franklin, Johnson, Linn, Miami, Osage*North Central Flint Hills Area Agency on Aging***785-776-9294 / 800-432-2703 / 785-776-9479 (fax)**

401 Houston, Manhattan, KS 66502

County: Chase, Clay, Cloud, Dickinson, Ellsworth, Geary, Jewell, Lincoln, Lyon, Marion, Mitchell, Morris, Ottawa, Pottawatomie, Republic, Riley, Saline, Wabaunsee*Northeast Kansas Area Agency on Aging***785-742-7152 / 800-883-2549 / 785-742-7154 (fax)**

1803 Oregon, Hiawatha, KS 66434

County: Atchison, Brown, Doniphan, Jackson, Marshall, Nemaha, Washington*South Central Kansas Area Agency on Aging***620-442-0268 / 800-362-0264 / 620-442-0296 (fax)**

P. O. Box 1122, 304 S Summit, Arkansas City, KS 67005

County: Rice, McPherson, Reno, Kingman, Harper, Sumner, Cowley, Chautauqua, Elk, Greenwood

TOLL-FREE HOTLINE: 1-800-860-5260

SHICK WEB SITE

<http://www.kdads.ks.gov/shick>

How to Find SHIPs Outside the state of Kansas

- **Call 1-800-MEDICARE - (1-800-633-4227)**
- **Ask the SHICK Call Center Operator at 1-800-860-5260**
- **Go to: <https://www.shiptacenter.org/>**
 - **Under “Find a State SHIP”, click on the box “Select a State”**
 - **Select the preferred state**
 - **Click on the Go button**
 - **The state’s SHIP Profile page will open**

Chapter 2

MEDICARE OVERVIEW

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MEDICARE OVERVIEW

Medicare is a federal health insurance program which began in 1965. States are not involved in the program's administration. In general, the rules governing Medicare's operation are the same nationwide, though more detailed rules sometimes apply in specific states or regions and payments rates often vary from one region to another. Still, the program is virtually the same throughout the country.

Medicare is not free for the people, called beneficiaries, who benefit from the program. Congress designed Medicare so beneficiaries would share the total cost of health care with the federal government through:

- Premiums
- Deductibles
- Coinsurance charges, and
- Payment for non-covered (excluded) services and items

Eligibility for Medicare is available to three groups: those who are 65 and older, people with disabilities, and people with end-stage renal disease (ESRD). Medicare eligibility is open to people regardless of income. Eligibility is not based on financial need. In that respect, Medicare differs greatly from Medicaid, the state-sponsored health insurance program for low-income older Americans and others. Instead, Medicare is tied largely to employment. The financing for Medicare Part A's Hospital Insurance benefits, for example, derives from a FICA withholding tax applied to wages.

Medicare has a fairly comprehensive set of covered benefits. It also offers a number of service delivery options. Beneficiaries have the option to receive services through the "Original Medicare" program (Medicare Parts A and B, also called "Traditional Medicare") or through a variety of privately sponsored "Medicare Advantage" plans. Regardless of the choice they make between these options, beneficiaries have coverage for the Part A benefits that include inpatient hospital, skilled nursing facility, home health, and hospice care services. They also have coverage for Medicare Part B's benefits that include physician, outpatient hospital, home health, ambulance, and preventive services, along with medical equipment, supplies, and many other services and items.

The Medicare Advantage program is another name for Medicare Part C. Congress enacted Part C in 1998, and through it, set up several different systems for delivering Medicare-covered benefits and services through private contractors. These contractors, called "health plan sponsors" or Medicare Advantage Organizations (MAOs), offer Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private-Fee-for-Service (PFFS) plans, and more, to Medicare beneficiaries. These private plans must cover the same services and benefits that are available through the Original Medicare program.

In 2003, Congress enacted the Medicare Modernization Act (MMA) and created the Medicare Part D prescription drug program. From the start, the Original Medicare program did not cover most outpatient prescription drugs. Medicare Part D addresses this shortcoming by delivering drug coverage through privately-sponsored prescription drug plans (PDPs) and Medicare Advantage plans with Part D drug coverage (MA-PDs). The Part D program also offers assistance for low-income Medicare beneficiaries through a low-income subsidy (LIS), or "Extra Help" program.

Medicare covers health care services only when they meet Medicare's definitions for medical necessity. With some exceptions, a service must be "reasonable and necessary in the diagnosis or treatment of an illness or injury" in order to qualify for Medicare payments. Nonetheless, Congress has added a number of health care screening and preventive care services to Medicare's covered benefits since 1990.

Medicare Card Prior to April 2018

The Medicare card shows if the individual has Part A and/or Part B. It is important to establish with beneficiaries which Part(s) they have. The suffix following the Social Security number on the card explains how the person is eligible for benefits. (See the chart in the Appendix.)

A husband and wife will each have their own card and number. The Medicare card should be carried by the beneficiary only at times when the beneficiary is seeking medical treatment, to avoid identity theft. If it is lost, the Social Security office should be contacted immediately to obtain a new one. A beneficiary should never permit another person to use their Medicare card.

- The Medicare card shows the beneficiary's name, claim number, and what parts of Medicare the beneficiary has, along with the effective dates for each part.
- Name of Beneficiary: Each individual gets a card with his/her name.
- Claim Number: Also referred to as the Health Insurance Claim Number (HICN), a nine-digit number (usually Social Security number) plus a suffix of one or two letters is listed. The letter indicates how the beneficiary qualifies for Medicare. This number should be included on all claims and Medicare correspondence. If the beneficiary or spouse worked for the railroad, the Medicare number will be a nine-digit number with a prefix of one or two letters. (See the suffix listing in the Appendix.)
- Is Entitled To: Show which Part(s) the beneficiary has. Some cards may list only "Hospital Insurance" and/or "Medical Insurance" rather than Part A and Part B. Newer cards will list "Hospital Insurance (Part A)" and/or "Medical Insurance (Part B)". (There are no lines for Part C or D, as a separate card is issued for those benefits by the private insurance company.)
- Effective Date: Indicates the date coverage started. Benefits are not payable before this date.

EXAMPLES:

Your Medicare Card Front View

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL MEDICAL (PART A)

EFFECTIVE DATE
07-01-1986

SIGN HERE _____

Your Medicare Card Back View

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you receive hospital, medical, or health services under Medicare.
3. Your card is good wherever you live in the United States.

WARNING: Fraud only for use of the medical community. The fraudulent use of this card is unlawful and will make the offender liable to penalty. If found, drop in nearest U.S. Mailbox.

CMS

Centers for Medicare & Medicaid Services
Baltimore, MD 21244-1650
From 24x7: 1-800-633-4227

If you have questions about Medicare,
call 1-800-MEDICARE
(1-800-633-4227;
TTY/TDD: 1-877-486-2048)
or visit us at
www.medicare.gov.

New Medicare Numbers and Cards

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Between April 1, 2018 and April 1, 2019, CMS be removing Social Security numbers from Medicare cards and mailing each person a new card. This will help keep people's information more secure and help protect their identity.

A new Medicare Number that's unique will only be used for Medicare coverage. The new card won't change coverage or benefits. Medicare will provide more information when new cards are mailed.

The new cards will no longer include gender or a signature line. They will also be smaller, the size of a standard credit card to fit in wallets easier and can be laminated.

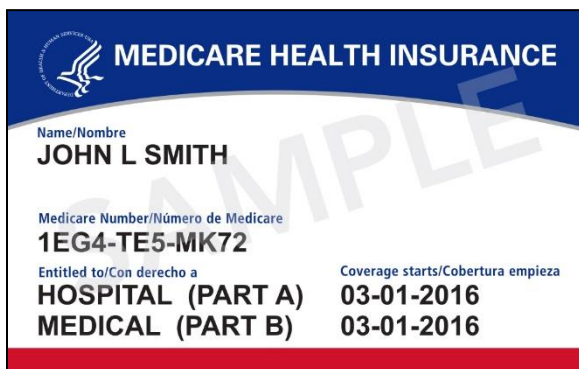
How will the MBI look?

The MBI will be:

- Clearly different than the HICN and RRB number
- 11-characters in length
- Made up only of numbers and uppercase letters (no special characters)

Will the MBI's characters have any meaning?

Each MBI is unique, randomly generated, and the characters are "non-intelligent," which means they don't have any hidden or special meaning. MBI format specifications can be found in Chapter 14 – Appendix page 14-16.



Ambulance Services

Medicare pays for ambulance services when the ambulance provider and the patient's situation meet certain conditions of coverage. The ambulance service provider must be Medicare-certified, meaning that the equipment and personnel comply with federal standards. Medicare then considers such factors as the severity of the beneficiary's condition and the distance to the nearest emergency facilities. Generally, Medicare only covers ambulance services in a locality (with some exceptions) to/from a hospital, skilled nursing facility (SNF), some other treatment facilities (e.g., dialysis centers), and the beneficiary's home.

Medicare covers ambulance services when, given the patient's condition, other transportation modes are "contraindicated," meaning that the other transportation could endanger the person's health. If a patient could use some other means of transportation without danger (even if that transport is not available), Medicare rules say that the ambulance trip is not medically necessary and cannot be covered.

EXAMPLE: *A beneficiary who fractures his collarbone in a fall may be able to travel safely to an emergency room in a car. But if he has other conditions or injuries that complicate the situation and endanger his health, Medicare may pay for an ambulance trip. Physician and ambulance service provider documentation is essential to Medicare payment.*

Medicare pays for ambulance trips to the "nearest appropriate facility," i.e., the nearest institution (for example, hospital or skilled nursing facility) that is generally equipped to provide the care for the illness or injury involved. It makes no difference if a patient's attending physician has staff privileges at the nearest hospital. If an institution has no bed available, however, it is not an appropriate facility and Medicare will pay for the trip to a more distant facility with an open bed. If an ambulance takes a patient to a facility beyond the nearest appropriate facility, Medicare limits its payment to the cost of transport to the nearer facility.

Medicare has special rules for non-emergency ambulance transportation. It only pays for non-emergency transport when the patient cannot get up from bed without assistance, or cannot walk or sit up in a chair or wheelchair. If the patient meets this condition, Medicare may pay for ambulance transport from a facility to the person's home.

Medicare also covers air ambulance services when ground transport is not medically appropriate. This occurs when the time or instability involved in transporting a patient by ground ambulance threatens their survival or seriously endangers their health. Some examples of these serious situations are intracranial bleeding that requires immediate neurosurgery, multiple serious injuries, and treatment in a hyperbaric oxygen unit. The nearest appropriate facility rule applies to claims for air ambulance payment.

Preventive and Screening Services

Medicare Part B covers a growing array of screening and prevention services. Medicare began covering common screening procedures in 1991 after Congress added screening mammograms and other screening services to Medicare's covered benefits. In many cases, Medicare waives the Part B annual deductible, the 20% coinsurance charge, or both for these services.

Preventive Services and Screenings Covered by Original Medicare without a Coinsurance or Deductible

Currently, Medicare's covered screening services are:

- Abdominal Aortic Aneurysm (AAA) screening for those at high risk, once in lifetime

- Alcohol misuse screening, once a year, and counseling, up to 4 times a year
- Bone mass measurements once every 24 months; more frequently if medically necessary
- Breast Cancer Screenings
 - Mammogram screening once every 12 months for women 40+; women between ages 35 and 39 can get one baseline mammogram
 - Breast examination once every 24 months, if at risk, once every 12 months
- Cardiovascular disease (behavioral therapy) once a year
- Cardiovascular disease screening for high-risk persons once every five years
- Cervical and vaginal cancer screening (Pap smear screening and pelvic exams every two years; more often for high-risk women)
- Colorectal cancer screening
 - Fecal occult blood tests once every 12 months for people age 50 and older
 - Colonoscopy once every 10 years
 - Flexible sigmoidoscopy once every 48 months
- Depression screening once a year
- Diabetes screening tests once every 12 months if you have a family history or are at risk for diabetes, twice a year if you have been diagnosed with pre-diabetes
- Hepatitis C Screening Test, one time
- HIV screening once every 12 months or up to three times during a pregnancy
- Immunizations
 - Flu shots once a season
 - Pneumococcal shot to prevent pneumococcal infections (like certain types of pneumonia). Also covers a different second shot if it's given at least 11 months after the first shot.
 - Hepatitis B vaccine only for people at medium to high risk
- Medical nutrition therapy for people with diabetes or kidney disease – yearly
- Obesity Screening and Counseling
 - Requires a body mass index (BMI) of 30 or more
 - Medicare covers behavioral counseling sessions to help you lose weight.
- Prostate cancer screening
 - Prostate specific antigen (PSA) test: once every 12 months
 - Digital rectal examination: once every 12 months
- Sexually transmitted infections screening and counseling
- Tobacco Use cessation counseling
- “Welcome to Medicare” preventive visit for new Medicare beneficiaries (if received in the first 12 months of Medicare coverage)
- Annual Wellness Visit

Services Covered by Original Medicare WITH Coinsurances and/or Deductibles

- Glaucoma screening for persons at high risk (once every 12 months)
- Prostate cancer screening – digital rectal exam once every 12 months
- Colorectal Cancer screening - Barium enema once every 48 months or every 24 months if you are at high risk
- Diabetes testing devices and supplies
- Diabetes self-management training

Providers who enter private contracts cannot receive Medicare payments for two years. Neither the provider nor the beneficiary can submit the claim to Medicare or to a Medicare supplement (Medigap) insurance plan, meaning that the beneficiary pays the entire bill out-of-pocket. Physicians, however, cannot require beneficiaries to enter a private contract in emergency situations. Physicians who enter private contracts must forgo Medicare payments for all Medicare patients for two years.

Other Things You Should Know About Medical Services Available

Coverage of Second Opinions

Sometimes your doctor may recommend surgery for the treatment of a medical problem. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

If the second doctor doesn't agree with the first, you may feel confused about what to do. In that case, you may want to do the following:

- Talk more about your condition with your first doctor
- Talk to a third doctor (Medicare helps pay for a third opinion) Getting a second opinion doesn't mean you have to change doctors. You decide which doctor you want to do your surgery.

Medicare Part B helps pay for a second opinion just as it helps pay for other doctors' services that are medically necessary. If you have Medicare Part B and are in the Original Medicare Plan,

- Medicare pays 80% of the Medicare-approved amount for a second opinion.
- Your share is usually 20% of the Medicare-approved amount after you have paid your yearly Part B deductible. The Part B deductible may increase each year.
- If the second opinion doesn't agree with the first, Medicare pays 80% of the Medicare-approved amount for a third opinion.
- If you decide to have the surgery, Medicare Part B covers the doctor's services, and Medicare Part A (Hospital Insurance) covers other hospital services.

If you are in a Medicare Health Plan (MA), you have the right to get a second opinion. Some MA plans such as HMOs will only help pay for a second opinion if you first get a referral from your primary care doctor. (A referral is a written OK). After you get a referral, you must get the second opinion from the doctor named in the referral. If you want to get a second opinion from a doctor who doesn't belong to your plan, talk to your plan first. In some cases, HMO plans will help pay for this. If your plan won't pay, you could still get the second opinion from the doctor who doesn't belong to your plan, but you would have to pay the full cost. Call your plan for more information.

If you are in a Medicare Preferred Provider Organization (PPO) or a Medicare Private Fee-for-Service Plan, your plan will help pay for a second opinion. You don't need a referral. If you are in a PPO, you may have to pay more if you get a second opinion from a doctor who doesn't belong to your plan.

If you belong to any of the above plans, and the first two opinions are different, these plans will help pay for a third opinion. Call your plan for more information.

Financial Liability Protection—Part B

Under the Original Medicare plan, there are protections under both Medicare Part A and Medicare Part B for beneficiary if Medicare decides that they received care that was not medically necessary or that is not covered by Medicare.

Limitation on Liability

In certain cases, even if Medicare denies your claim, you will not be held responsible for paying the doctor or other health care provider. These cases fall under the “limitation on liability” (waiver of liability) provision of the Medicare law. This limitation on liability applies only when the following three requirements are met:

- The services are furnished by an institutional provider, such as a hospital, skilled nursing facility, or home health agency that participates in Medicare, or by a doctor or other supplier who “accepts assignment.”
 - Medicare denied the claim for one of the following reasons:
 - The care provided was custodial care.
 - The care was not “reasonable and necessary” under Medicare program standards for diagnosis and treatment.
 - For home health services, the patient was not homebound or did not require skilled nursing care on an intermittent basis.
 - The only reason for the denial is that, in error, the beneficiary was placed in a Skilled Nursing Facility bed that was not approved by Medicare.
- The beneficiary did not know, or could not reasonably be expected to know, that Medicare does not cover the services given. (For example, the beneficiary did not know because they did not receive a written notice, Advance Beneficiary Notice – ABN.)

In certain situations, Medicare law will protect the beneficiary from paying for doctor services provided on a non-assigned or assigned basis that are denied because they are “not reasonable or necessary.” If the doctor knows or should know that Medicare will not pay for the service, the doctor is required to give the beneficiary written notice in advance that tells them why Medicare will not pay for it. If they do not get this written notice, they will not have to pay for the service or they may be entitled to a refund from the doctor.

Advance Beneficiary Notice of Noncoverage (ABN)

There are two situations where a doctor or health care provider must give a written notice (called an Advance Beneficiary Notice of Noncoverage – ABN), in advance, that the care **MAY NOT** be paid by Medicare:

1. Before the doctor or provider gives you a service that they believe Medicare doesn’t consider medically necessary;
2. When they know or believe that Medicare will not pay for the service.

If the beneficiary is not given an ABN before they receive the service, they are not responsible for paying for the service. But if they do receive a written notice, sign an agreement, receive the service and Medicare does not pay for the service, the beneficiary must pay for it.

An Advance Beneficiary Notice is for use by the provider *before* service is given. It **protects** the provider and **informs** the beneficiary.

CMS Website to read Beneficiary Notices:

http://www.cms.hhs.gov/BNI/01_overview.asp

Chapter 5

MEDICARE PART C (Medicare Advantage)

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Medicare Part C (Medicare Advantage)

Medicare Advantage is a system for delivering Medicare benefits to beneficiaries who enroll in plans offered by private health insurance organizations. Private Medicare plans agree to coordinate the care received by beneficiaries and reduce costs by emphasizing prevention and limiting the use of services. The Original Medicare program, in contrast, typically pays for care on a fee-for-service basis.

Eligible beneficiaries must choose to enroll in a MA plan. That is, eligible beneficiaries must enroll in a MA plan during an applicable enrollment period, and generally agree to stay in the plan for a calendar year, in order to receive coverage through the Medicare Advantage program. After enrollment in a MA plan takes effect, beneficiaries typically must receive all of the care according to plan rules, respecting provider network, prior authorization, and other limits that plans may use to control spending.

The Centers for Medicare and Medicaid Services (CMS) pays private MA plans a fixed amount per beneficiary to provide care. The amount CMS pays to the plans is not directly related to the quantity or cost of health services they deliver. This payment method is called capitation. It contrasts with Original Medicare's fee-for-service system in which Medicare pays physicians and other healthcare providers for each service they provide to Medicare beneficiaries.

In 2016, nearly 32% of Medicare beneficiaries were enrolled in Medicare Advantage plans. Since enrollment into a Medicare Advantage plan changes fundamental aspects of how Medicare beneficiaries receive their health care, it is more important than ever for people to have access to timely, accurate, and useable information about these plans before they enroll. SHIPs have an important role in providing thorough counseling and information to Medicare beneficiaries about all their Medicare options so that they can make informed decisions about their benefits.

Types of Plans

In order to receive health coverage through a Medicare Advantage (MA) plan, beneficiaries need to enroll in an available plan. While all MA plans are set up under the Medicare Part C program, the law allows plan sponsors to take very different approaches to structures for coverage, provider networks, and payment. Plan sponsors offer several types of plans. These include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans, Special Needs Plans, and PACE plans. This section provides in-depth descriptions of the different MA plans available across the country.

Medicare Advantage plans are offered in a specific geographical area, with exceptions for some employer/union sponsored MA plans that have retirees living in different areas. Generally, beneficiaries must live within a plan's service area to be considered eligible for enrollment in the MA plan. A service area may be as small as one county or as large as multiple MA regions. Within a MA plan's service area, the plan must provide all enrollees an identical package of benefits with an identical cost-sharing structure.

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are a type of Coordinated Care Plan (CCP) that operates through a network of health care providers. HMOs contract with hospitals, physicians, laboratories, and other providers to create their provider networks. Plans may offer incentives to network providers to help in the effort to contain costs or to meet certain quality of care standards. Most HMOs require people who enroll in the plan to choose a primary care provider (PCP). The PCP is often a physician who is expected to act as a gatekeeper to health care services. HMO plan members, or "enrollees," generally must contact

- SNPs also must apply one of the following structures:
 - The plan may target one chronic condition from the list of approved chronic conditions (see above).
 - The plan may target a group of commonly co-morbid and clinically linked chronic conditions from a list of approved common multi-condition groupings in which the eligible beneficiary has at least one condition. The groupings include diabetes mellitus and chronic heart failure; chronic heart failure and cardiovascular disorders; diabetes mellitus and cardiovascular disorders; diabetes mellitus, chronic heart failure, and cardiovascular disorders; and stroke and cardiovascular disorders.
 - The plan may target a plan-designed grouping of multiple chronic conditions from the list of approved chronic conditions in which the eligible beneficiary has all conditions

Private Fee-for-Service (PFFS) Plans

Private Fee-for-Service (PFFS) Plans are a type of Medicare Advantage (MA) plan that is very different from Coordinated Care Plans. Beneficiaries don't need to choose a primary care doctor in PFFS Plans. PFFS plans resemble Original Medicare in that the plans pay providers for each service they deliver to plan enrollees. They are also similar in that enrollees are not limited to a network of health care providers and do not need referrals to see a specialist. On the other hand, unlike Original Medicare, PFFS plans set their own payment rates for health care providers. Thus, enrollees may see any provider who agrees to accept the plan's payment terms, but CMS does not require providers to accept these terms. Because of this, it is critical to know that any Medicare provider, including physicians, home health agencies, and equipment suppliers, **may choose to accept, or not accept, the terms of the PFFS plan each time a patient visits the provider**. This means that enrollees cannot trust that their preferred doctors and hospitals will remain PFFS providers even if they received covered services through these providers previously.

Starting in 2011, non-employer/non-union PFFS plans that are operating in areas with more than one MA network-based plan must meet the access standards of other MA network-based plans. Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before. Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before. For each service you get, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms. In an emergency, doctors, hospitals, and other providers must treat you. You only need to pay the copayment or coinsurance amount allowed by the plan for the type(s) of service you get at the time of the service.

Private Fee-for-Service plans may or may not offer Medicare drug coverage through the PFFS. Unlike many other types of MA plans, enrollees in PFFS plans without Medicare drug coverage (PFFS-only) may enroll in a stand-alone Prescription Drug Plan (PDP).

Programs for All-Inclusive Care for the Elderly (PACE)

The Program for All-Inclusive Care for the Elderly (PACE) is a model that provides community-based medical, psychosocial, long-term care, and chronic care to frail older adults. An interdisciplinary team manages participants' care to keep them out of nursing homes as long as possible by providing adult day center and home-based care services.

To qualify for PACE services, an individual must be age 55 or older, certified by the state to need nursing home care, have the ability to live in the community safely and live within a PACE service area. PACE programs receive monthly Medicare and Medicaid capitation payments for each qualifying participant, and those who are not eligible for these benefits must privately pay the capitation amount. Capitation allows

PACE programs to provide a variety of services, even some that Medicare or Medicaid may not typically cover, through a determined monthly payment for each individual.

PACE delivers most of its services from a day health center which members attend several times a week. The day health center provides primary medical care, physical, occupational and recreational therapies, personal care, social services, and transportation to and from the center. Home-based services often supplement the center-based services.

Eligibility and Enrollment

Given the many choices that Medicare beneficiaries face in terms of receiving their health insurance and drug coverage, it is essential for SHICK counselors to help clients assess if a Medicare Advantage (MA) plan will meet their health insurance needs. The first step in that process is to determine if a client is eligible to enroll in a MA plan. Here are three key questions counselors should ask to assess a client's eligibility for enrolling in a MA plan.

- **Is your client enrolled in Medicare?** Generally, to be eligible to enroll in a Medicare Advantage plan, a Medicare beneficiary must be enrolled in both Medicare Part A and Part B.
- **Does your client have end-stage renal disease (ESRD)?** Except in certain circumstances, beneficiaries may not be medically determined to have end-stage renal disease (ESRD) at the time of enrolling in a MA plan. Individuals who develop ESRD while enrolled in a MA plan may continue to be enrolled in the plan. Beneficiaries who have ESRD may also enroll in a Special Needs Plan (SNP) that is open for enrollment to those with ESRD.
- **Does your client live in the MA plan's service area?** Beneficiaries must permanently reside in a Medicare Advantage plan's service area to be able to enroll in the plan. Service areas differ among the various types of MA plans. Service areas may be no larger than a few counties in a metropolitan area or they may encompass an entire state or a multi-state region. Since provider network rules vary by plan as well as by plan type, it is especially important for beneficiaries who live out of a plan's service area for some part of the year to consider this factor.

When eligible beneficiaries decide to join a MA plan, they must complete an enrollment form to elect, or enroll in, a MA plan. It is very important to note that Medicare beneficiaries who choose to enroll in a Medicare Advantage plan remain "in Medicare." Often beneficiaries think that they are leaving Medicare when they join a MA plan. Counselors may need to address the sources of this confusion, which may include marketing materials and a MA plan's use of its own membership card instead of a beneficiary's regular Medicare card. While MA coverage through a private plan replaces the Part A Hospital Insurance and Part B Supplemental Medical Insurance that provide coverage to beneficiaries in Original Medicare, MA enrollees retain the rights of all Medicare beneficiaries, including the right to return to Original Medicare.

Finally, except for beneficiaries enrolled in Medicare Medical Savings Account (MSA) plans and those enrolled in Private-Fee-for-Service (PFFS) plans and Cost plans that do not offer qualified prescription drug coverage, individuals may not be enrolled into both a MA plan and a stand-alone Medicare Prescription Drug Plan (PDP) at the same time.

Deciding to Enroll in a MA Plan

MA plans may help some Medicare beneficiaries lower their out-of-pocket spending and gain access to benefits beyond those in Original Medicare.

SHICK counselors provide a unique and essential service for clients when guiding them through a process to reach sound decisions about MA plan enrollment. To continue the assessment process that began with determining eligibility, counselors should learn as much as possible about a client's interest in particular MA plans. Here are some likely reasons for that interest:

- **Low premiums:** Some MA plans have very low monthly premiums. When compared to the cost of Medicare Supplement (Medigap) insurance policies or retiree group health plans, some of your clients could save several hundreds of dollars annually on insurance premiums by enrolling in a MA plan. The prospect of lower monthly health insurance premiums alone motivates many people to consider MA plans.
- **Extra Benefits:** Most MA plans offer benefits that the Original Medicare program excludes from coverage. Typically, these extra benefits can include routine dental and vision care.
- **Simplicity:** MA plans often combine the benefits that Original Medicare and Medicare Part D make available, along with some features of supplement insurance, in a complete package with one monthly premium. Some people prefer this to Original Medicare in which beneficiaries often pay separate premiums for Medigap insurance and Part D prescription drug benefits. Many MA plans also use set copayment amounts of \$10 or \$20 for each physician visit instead of Original Medicare's less predictable Part B 20% coinsurance charge.
- **An Affordable Alternative to Medicare Supplement Insurance:** Because MA plans cover some of the benefit gaps in Original Medicare, and because they are billed as a modern insurance option with more "advantages," some of your clients may believe that MA plans take the place of Original Medicare and supplement insurance, or that the MA plans and Medigap insurance are equivalent. This is a misimpression that SHICK counselors must address with patience and the use of case examples that illustrate how the out-of-pocket costs in MA plans and Medigap insurance differ.

After taking some time to listen to the reasons for a client's interest in a MA plan, it is important next for counselors to address several factors that beneficiaries should consider before joining a Medicare Advantage plan. Here are some considerations:

- **Plan Rules:** Enrollees in MA plans must follow the rules of the Medicare Advantage plan in order to receive coverage and payment. For example, a common rule in Medicare HMOs is one that requires use of network providers, including doctors, hospitals, and diagnostic facilities. Another common rule in HMOs requires patients to get referrals to see specialists. Many MA plans, including HMOs and Private Fee-for-Service (PFFS) plans, also have prior authorization or prior notification rules that apply, for example, to medical equipment and elective surgery. Enrollees who do not follow their MA plan's rules may be responsible for the entire cost of care.
- **Lock-In:** Beneficiaries who opt to join a MA plan should understand the concept of lock-in. Individuals may make changes only during limited enrollment periods (e.g., the OEP and MA OEP). Once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year. This lock-in feature does not apply to beneficiaries who have a SEP.
- **Out-of-Pocket Costs:** Since the majority of Medicare beneficiaries have moderate incomes, it is tempting for some people to compare MA plans and Original Medicare with a Medigap policy by premiums alone. But the true cost of a MA plan includes the monthly premium plus the cost-sharing charges for various services. MA plans set their own cost structure, so a plan could offer a low monthly premium and offset it by charging more for individual covered services. While MA plans commonly use

defined copayments for inpatient hospital and physician services, many use percentage-based coinsurance charges for outpatient hospital care and medical equipment and supplies. In some plans, beneficiaries owe out-of-pocket 20% of the cost for outpatient surgery and other treatments. In contrast, those in Original Medicare may purchase a Medigap policy that pays all of the beneficiary's cost-sharing for inpatient and outpatient hospital services, and the entire coinsurance charge for medical equipment and supplies.

- **Beneficiary Liability for Cost-Sharing:** MA plan members must be prepared to cover the plan's out-of-pocket costs with their own income or financial resources. Thus, it is critical for people to examine a MA plan's cost-sharing structure and for counselors to show through case examples how the cost-sharing system works, before your clients enroll in a MA plan.
- **Access to Providers:** Some MA plans have health care provider networks with restricted access to "out-of-network" providers. Provider networks are common in Medicare HMOs and PPOs. Some HMO and PPO plans' networks are very large, while others are more limited. Medicare PFFS plans, on the other hand, make payments to any health care provider who is willing to accept the plan's payment terms. Doctors, hospitals, and other service providers can pick and choose among the PFFS plans whose payments they will accept. With respect to providers, counselors should encourage clients to think about a MA plan's ability to ensure access to the hospitals, doctors, home health agencies, and diagnostic centers they prefer to use.
- **Peace of Mind:** Some people who enroll in MA plans face surprisingly large out-of-pocket costs when an unexpected illness or accident requires a series of outpatient hospital visits for treatment or rehabilitation. Others are stunned when an out-of-town diagnostic center does not accept a MA plan's payments, leaving them to foot the entire bill for expensive procedures. To promote peace of mind, counselors can help clients weigh the benefit of a MA plan's potential savings with some of its inherent uncertainties and risks. With clients who are "on the fence," counselors should recall that those who enroll in MA plans can return to Original Medicare during an annual Open Enrollment Period (OEP), the MA Open Enrollment Period (MA OEP), or a Special Enrollment Period (SEP). In limited cases, clients have special rights to return to Original Medicare and purchase Medigap insurance.

CMS has an online tool that provides information about Medicare Advantage plans, called the Medicare Plan Finder. It is available at <http://www.medicare.gov/>. Coverage and cost information about each plan is located in the Medicare Plan Finder by clicking on the plan's name. Through this online tool, SHICK counselors can help beneficiaries narrow the list of available MA plans in their state. The tool allows you to further limit the list of MA plans in a state with additional screening criteria—including but not limited to:

- Plans that charge no more than a certain monthly premium and/or deductible
- Plans that allow an enrollee to visit any doctor and other coverage options
- Plan Star Rating

While the Medicare Plan Finder gives a lot of information about the coverage and cost features in MA plans in summary and detailed forms, even the detailed information may not provide all of the specifics that a client needs to make an informed decision, such as contracted providers. Thus, further research may be required. Typically, you can find more information about a MA plan through its website or toll-free number.

The Medicare website also has a comparison tool for Medigap policies available in the state. Since beneficiaries sometimes enroll in a Medicare Advantage plan as an alternative to buying Medigap insurance, this tool does provide a method to evaluate both sets of options.

Enrollment Periods and Effective Dates

CMS does not allow continuous open enrollment for the Medicare Advantage program. While some low-income beneficiaries may make enrollment changes more often, most beneficiaries have limited time frames to enroll in, disenroll from, or switch MA plans. Most people who enroll in MA plans are “locked in” to their plans for a calendar year. Beneficiaries must complete an enrollment form to elect, or enroll in, a MA plan.

There are three enrollment period categories: initial, yearly, and special enrollment. A beneficiary’s first chance to enroll in Medicare, and thus to choose a Medicare Advantage plan, is called the Initial Enrollment Period (IEP). The IEP often coordinates with a beneficiary’s Part D Initial Enrollment Period (IEP). Yearly scheduled enrollment periods (including the annual Open Enrollment Period and MA Disenrollment Period) are set times of year when the law permits beneficiaries to make changes to their Medicare coverage. Special Enrollment Periods (SEPs) enable beneficiaries with special situations to make plan changes outside of initial or yearly opportunities. For example, SEPs permit beneficiaries who move out of a plan’s service area or who lose other health coverage to make changes to their Medicare benefits.

Initial Coverage Election Period (IEP)

The Initial Coverage Election Period (IEP) is the seven-month time frame during which a person who is newly eligible for Medicare (enrolled in both Medicare Part A and Part B) may choose to enroll in an Medicare Advantage plan for the first time. The IEP begins three months before entitlement to both Part A and Part B and ends either on the last day for the beneficiary’s Part B initial enrollment period or the last day of the month preceding entitlement to both Part A and Part B, whichever is later.

Generally, a person becomes eligible for Medicare on the first day of the month of his or her 65th birthday or the 25th month of disability. Part B enrollment may not occur upon entitlement to Part A for a variety of reasons; thus, the IEP typically coordinates with Part B entitlement or enrollment.

Yearly Opportunities for Enrollment: OEP and MA OEP

The MMA permits Medicare beneficiaries to make changes to their Medicare enrollment during the annual Open Enrollment (or Election) Period (OEP) each year. Medicare Advantage-eligible beneficiaries may use the OEP as an opportunity to enroll in or disenroll from a MA plan. They can use the OEP to switch from one MA plan to another or to leave the MA program for Original Medicare. The OEP runs from October 15 through December 7 each year. The new coverage choice becomes effective on January 1 of the following year. Beneficiaries who make more than one enrollment choice during the OEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change their minds throughout the OEP. While this may be helpful for some individuals, keep in mind that unscrupulous plan sales agents can undo the results of a counseling session with SHICK’s clients. Note that employer/union sponsored MA group plans need not conform to the OEP rules that apply to other MA plans.

The OEP is also a chance for all Medicare beneficiaries to enroll in or disenroll from a Medicare drug plan. A decision to enroll in or disenroll from Medicare drug coverage during the OEP is effective for the following calendar year, beginning on January 1. Only beneficiaries who have a Special Enrollment Period (SEP) opportunity may change their Medicare drug plan enrollment during the plan year.

Medicare Advantage Open Enrollment Period (MA OEP)

The 21st Century Cures Act eliminates the existing MA disenrollment period that currently takes place from January 1st through February 14th of every year and, effective for 2019, replaces it with a new Medicare Advantage open enrollment period (OEP) that will take place from January 1st through March 31st annually. The new OEP allows individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or Original Medicare. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage. An MA organization has the option to voluntarily close one or more of its MA plans to OEP enrollment requests. If an MA plan is closed for OEP enrollments, then it is closed to all individuals in the entire plan service area who are making OEP enrollment requests. All MA plans must accept OEP disenrollment requests, regardless of whether or not it is open for enrollment. Individuals with enrollment in Original Medicare or other Medicare health plan types, such as cost plans, are not able use the OEP to enroll in an MA plan, regardless of whether or not they have Part D.

The types of changes beneficiaries can make during the MA OEP are listed in the table below. An enrollment choice made during the MA OEP is in effect for the entire remaining calendar year starting on the effective date of coverage, unless a beneficiary has a SEP opportunity.

Important: If the beneficiary disenrolls from a Medicare private health plan (Medicare Advantage), federal law does not give the beneficiary the right of guarantee issue to buy a Medigap plan.

Type of Coverage on January 1	Allowed During MA OEP
MA-PD	<ul style="list-style-type: none"> MA-PD
MA-only	<ul style="list-style-type: none"> MA-only Original Medicare + PDP Original Medicare w/o PDP
Original Medicare only or with a PDP	<ul style="list-style-type: none"> No changes allowed

Another OEP enrollment opportunity, called the OEPI, exists for people in institutions. The OEPI is a continuous enrollment period for all Medicare beneficiaries who move into, reside in, or move out of an institution. The OEPI permits them to make unlimited changes to their MA or Original Medicare enrollment. For the purpose of the OEPI, the term “institutionalized” includes those residing in the following facilities:

- Skilled nursing facilities (SNFs)
- Nursing facilities (NFs)
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Psychiatric hospitals
- Rehabilitation hospitals
- Long-term care hospitals
- Swing-bed hospitals

Special Enrollment (Election) Periods

Special Enrollment (Election) Periods (SEPs) enable Medicare beneficiaries to make certain enrollment changes in several special situations. As a SHICK counselor, it is important to keep in mind that these SEP opportunities exist because they may enable some of your clients to make changes in their MA enrollment outside of the OEP and MA OEP.

CMS’s enrollment guidance describes a SEP this way:

Special election periods constitute periods outside of the usual IEP, OEP, or MA OEP when an individual may elect a plan or change his or her current plan election.... Depending on the nature of the particular special election period, an individual may:

- Discontinue an enrollment in a MA plan and enroll in Original Medicare
- Switch from Original Medicare to a MA plan
- Switch from one MA plan to another MA plan

Certain SEPs are limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may subsequently elect a new MA plan within the SEP time period. Once the individual has elected the new MA plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. **In other words, the SEP for the individual ends when the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.**

In addition to MA-specific SEPs, there are certain other SEPs that correspond to Prescription Drug Plans (PDPs).

Change in Residence

Two circumstances give persons the right to a SEP for a change in residence. This includes those who have a change in permanent residence that places them outside of their MA plan's service area and those who have new MA and/or Part D plans available as a result of a change in permanent residence.

This SEP has certain notice procedures. For people who notify their plan in advance of their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months.

When individuals do not notify their plan of their move, and the plan learns from CMS or otherwise that they have lived outside of their plan's service area for more than six months, their SEP begins in the sixth month and continues through the eighth month after the move. Persons may request that the effective dates of their SEP enrollments to be up to three months after the notification but not earlier than the date of the move.

Contract Violation

MA plan enrollees who demonstrate to CMS that the MA organization violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another MA plan or to Original Medicare. SHICK can help plan enrollees submit requests for Contract Violation SEPs to their CMS Regional Office. CMS will process some of these enrollment requests as retroactive disenrollments/enrollments. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS.

Non-Renewals or Terminations

People whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 of the prior year to January 31 of the following year. CMS requires these plans to give 90 days' notice to enrollees. The effective date of the enrollment may be on January 1, or February 1, but not before the plan receives the enrollment request.

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month past the termination effective date. These plans are required to give 60

days' notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

Exceptional Conditions

- **SEP EGHP:** Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect a MA plan or vice versa during the period of time when the EGHP allows plan changes. The effective date of the enrollment may be up to three months after the request for enrollment or disenrollment but not before the plan receives the request.
- **Disenrollment Connected to a CMS Sanction:** If CMS sanctions a MA organization and enrollees disenroll due to the issue that led to the sanction, CMS may authorize a SEP on a case-by-case basis for those enrollees.
- **PACE Enrollees:** MA enrollees may disenroll at any time to join a PACE program. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join a MA plan.
- **Dual-Eligible Beneficiaries and upon Losing Dual-Eligibility:** All dual-eligible beneficiaries (including those with both Medicare and Medicaid and those who are in Medicare Savings Programs) have a SEP opportunity that begins upon becoming a dual-eligible beneficiary and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from a MA plan, including an MA-PD plan, at any time. Beginning in 2019, the beneficiary will be limited to a onetime per calendar quarter election between January through September. The effective date of the change is the first of the month following the request for the change.
- **Trial Period SEP:** People who drop a Medigap policy to enroll in a MA plan for the first time are entitled to a guaranteed right to purchase their own Medigap policy back or buy a new one, if the one they had is not available, within the "trial period," usually twelve months. The Trial Period SEP permits them to disenroll from a MA plan at any time during this trial period to return to Original Medicare and to purchase the Medigap policy. The SEP begins upon disenrollment from the MA plan and continues for two additional months, with an effective date depending on the situation.
- **Retroactive ESRD Entitlement**
- **Retroactive Medicare Entitlement**
- **Part D Coordinating:** These SEPs permit eligible persons to make an election into or out of an MA-PD plan (or as it applies below).
 - **Involuntary Loss of Creditable Coverage:** Medicare beneficiaries who experience an involuntary loss of creditable coverage or a reduction in such coverage that makes it no longer creditable have a SEP to permit enrollment into a Part D plan (including an MA-PD plan). The SEP begins upon notification of the loss (or reduction) and ends two months after the loss (or reduction) or the notice, whichever is later. The effective date is the first of the month following the request or may be up to three months prospective.
 - **Not Informed of Creditable Coverage:** Those not adequately informed of a loss of (or that they never had) creditable coverage have a SEP to enroll in a Part D plan (including an MA-PD plan). Established on a case-by-case basis, this SEP begins upon approval from CMS and continues for two additional months.

- **Error by Federal Employee:** On a case-by-case basis, CMS may grant a SEP to those whose enrollment or non-enrollment in a Part D plan (including an MA-PD plan) is not valid due to the action, inaction, or error of a Federal employee. This SEP begins upon approval from CMS and continues for two additional months. SHIPs can help plan enrollees submit requests to their CMS Regional Office.
- **Disabled Medicare Beneficiary Turning 65:** Beneficiaries eligible for Medicare due to a disability have an additional IEP for Part D upon turning 65. The coordinating SEP with this IEP may be used to disenroll from an MA-only or MA-PD plan and return to Original Medicare, or to enroll in an MA-only plan (regardless of whether the Part D IEP to enroll in a PDP is used). The SEP begins and ends concurrently with the additional Part D IEP.
- **Beneficiaries Losing Special Needs Status:** Those enrolled in a Special Needs Plan (SNP) who no longer meet the specific special needs status are eligible for a SEP. The SEP begins upon the change in status and continues for three more months.
- **Non-Dual-Eligible Beneficiaries with LIS and Upon Losing LIS:** LIS eligible beneficiaries who are not dual-eligible have a SEP opportunity that begins upon qualifying for LIS and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from a Part D plan, including an MA-PD plan, at any time. Beginning in 2019, the beneficiary will be limited to a onetime per calendar quarter election between January through September. The effective date of the change would be the first of the month following the request for the change.
- **Enrollment in a Chronic Care SNP:** A SEP exists for individuals who qualify for a Chronic Care Special Needs Plan (SNP) to enroll in an SNP. The SEP applies to all beneficiaries who qualify for these SNPs and ends upon enrollment into a plan.
- **Beneficiaries Who Require a New Chronic Care SNP:** An additional SEP exists for beneficiaries currently enrolled in a Chronic Care SNP who require a new SNP due to a new chronic care focus. The SEP ends upon enrollment into the new SNP.
- **Disenrollment from Part D to Enroll In or Maintain Creditable Coverage:** Any enrollee in a Part D plan (including PDPs and MA-PDs) may disenroll at any time from the plan to obtain or maintain other creditable coverage. The effective date of disenrollment would be the first of the month following the request. This SEP permits those leaving MA-PD plans also to enroll in an MA-only plan.
- **Beneficiaries who are released from jail.** Beneficiaries who are released from jail have a SEP to join a MA plan or Part D plan for two full months after the month they are released from jail.

SEP65

Beneficiaries who enroll in a MA plan (excluding an MSA plan) during their Initial Enrollment Period for Part B (the seven months around their 65th birthday) have a SEP65 to try out the Medicare Advantage program. These individuals may disenroll from the MA plan into Original Medicare at any time during the first twelve months of enrollment in the MA plan. They have a guaranteed issue right to any Medigap policy (not just plans A, B, C, F, K, or L).

5-Star SEP

In 2012, CMS introduced the 5-Star Special Enrollment Period. Under this SEP, a beneficiary can join or switch to a 5-Star MA plan (with or without drug coverage) or a 5-Star PDP in their service area. The time period for this SEP is December 8 through November 30 of the next year, with an effective date of the first of month following the enrollment request. It can only be used to enroll in plans given an overall 5-star rating for the current calendar year. The Star rating is from the ratings on the Plan Finder, not the current year Medicare & You Handbook. Beneficiaries can only use the 5-star SEP one time during the year. If the

beneficiary joins an MA-only plan which allows a stand-alone PDP, they also have a coordinating Part D SEP and can join a PDP for the same month. The PDP doesn't have to be a 5-star plan. However, if they are switching from one MA-only plan to another MA-only plan, they do not have an SEP to switch PDPs.

How to Enroll in a MA Plan

Beneficiaries eligible for the Part D low-income subsidy, and thus have auto or facilitated enrollment, may occasionally be auto or facilitated enrolled into a Medicare Advantage plan with drug coverage. This process only occurs in certain exceptional instances when a beneficiary is enrolled into an MA-only plan upon becoming eligible for the LIS. At that point, these beneficiaries would be facilitated into MA-PD plans to ensure their access to Medicare drug coverage.

Who Can Help a Medicare Beneficiary Enroll?

In most cases, Medicare beneficiaries themselves must complete applications to enroll in MA plans. CMS's MA Enrollment and Disenrollment Guidance explains that anyone other than the beneficiary who completes an enrollment request must state that he or she has the legal authority under state law to execute the enrollment.

NOTE: SHICK counselors who assist clients with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. Instead, SHICK counselors who help clients with Medicare Advantage plan enrollment are merely facilitating the process. Counselors can avoid problems by making sure that they do not indicate that they represent their clients, or sign enrollment forms on a client's behalf.

Plan Must Provide Certain Information to Enrollee

Prior to the effective date of enrollment (or within 10 calendar days of enrolling) a MA plan must provide all enrollees with the following documents:

- A copy of the enrollment form, where applicable
- A notice acknowledging receipt of the completed enrollment election showing the effective date of coverage
- Proof of health insurance coverage, including, where applicable, the data necessary to access prescription drug benefits

Materials must explain the following information to new enrollees:

- The costs associated with the MA plan, including but not limited to the premium, coinsurance, copayments, or fees and the amount that the plan contributes to the Medicare premium and deductible, if applicable.
- The lock-in requirement, including an acknowledgement from enrollees that they understand about the plan's provider network requirements.
- The effective date of coverage and steps to take to obtain services prior to the receipt of an ID card, if necessary.

Disenrollment

Medicare beneficiaries who are currently enrolled in a Medicare Advantage plan may only disenroll from that plan during certain periods: the annual Open Enrollment Period (OEP) from October 15 through December 7; during the MA Open Enrollment Period (MA OEP) from January 1 through March 31; and any applicable Special Enrollment Period (SEP).

Some Medicare Advantage plans may offer optional supplemental benefits to their enrollees. Only those enrollees who choose this optional coverage must pay an extra premium to receive the benefits. Optional benefits packages are similar to “riders” in other kinds of insurance. Medicare Advantage plans cannot use rebate dollars to reduce the actual costs of the optional supplemental premium.

Costs for Health Care Services

Federal law gives Medicare Advantage (MA) plans flexibility to create cost-sharing structures that differ from Original Medicare’s. MA plans may use percentage coinsurance charges, fixed copayment charges, or a combination of the two, depending on the service. Keep in mind that plans can change their cost-sharing structures and payment amounts yearly. CMS requires plans to notify plan members of these changes through an “Annual Notice of Change,” or ANOC.

While beneficiaries in Original Medicare may purchase a Medigap policy to pay for some of the out-of-pocket costs—or gaps—in Original Medicare, the law prohibits Medigap policies from coordinating with MA plans. At this time, there are no Medicare-approved policies, like a Medigap, to cover the out-of-pocket costs for Medicare Advantage enrollees. Enrollees in MA plans must be prepared to pay out-of-pocket for any and all deductibles, copayments, and coinsurance amounts. In 2011, CMS implemented regulations making total out-of-pocket spending more predictable by requiring annual spending caps for all MA plans. The caps limit plan members’ financial exposure to set dollar amounts. After a person reaches a spending cap, the MA plan covers the full cost of care for the rest of the year.

Billing for Services

Medicare Advantage billing is a process very similar to other commercial health insurance products. When a MA plan enrollee receives a covered service, the health care provider collects the copayment, if applicable, from the enrollee. Then the provider submits the claim to the plan. If the MA plan agrees to cover the service, the plan sends the provider a payment. If the MA plan declines to cover the service, the plan notifies the provider. It issues a written Notice of Denial of Payment to explain the reasons for its denial. In such cases, the provider may bill the enrollee for the full cost of the service. An enrollee who disagrees with a plan’s coverage denial (i.e., a plan’s “organization determination”) may initiate the appeals process.

Medicare Advantage plans may have restrictions on certain health services. For example, they may require enrollees to receive prior authorization for some services. If the physician requests prior approval for such a service and the MA plan denies the request, the plan issues a written Notice of Denial of Medical Coverage to explain its decision. When this happens, enrollees have a few options. First, they can start the appeals process. Second, they may file a grievance with the MA plan. Third, the physician may provide more information to meet the plan’s coverage requirements.

The prior authorization process is quite different from the way that beneficiaries in Original Medicare receive covered services. In Original Medicare, the beneficiary receives a service from a Medicare provider. At that point, Medicare decides whether the service is covered. If the service is not covered, the beneficiary may pay the bill or appeal the denial if he believes Medicare should have covered the service. In Medicare Advantage, an enrollee may have to request coverage for a service before receiving it. If the plan denies coverage the enrollee may pay out-of-pocket for the service or start an appeal. The key difference between these two delivery mechanisms is that under Original Medicare a beneficiary may have to appeal to receive payment for a service received. Under Medicare Advantage a beneficiary may have to appeal to receive the service itself.

In Original Medicare, beneficiaries receive a Medicare Summary Notice (MSN) every three months if Medicare has paid a claim on their behalf. The MSN outlines all of the services a beneficiary received, how much Medicare paid for the service, and the amount providers may bill the beneficiary for each service. Medicare Advantage does not have an official, standard, system like the MSN for providing notice to enrollees about services they received. CMS instead expects plans to “give the beneficiary prompt notice of acceptance or denial of claims in a format specified by CMS.” Most plans send an Explanation of Benefits (EOB) after they have paid for a service. For denials, they issue a form captioned *Notice of Denial of Payment*.

Low-Income Assistance

Some Medicare beneficiaries with limited income receive benefits from the state Medicaid program to pay some of the out-of-pocket costs associated with Medicare coverage. There are several levels of assistance, including full Medicaid benefits and the different categories of Medicare Savings Programs (MSPs).

Medicare beneficiaries who qualify for full Medicaid benefits are known as full dual-eligible beneficiaries (or “full duals”). Because full duals have few, if any, out-of-pocket expenses associated with their Medicare and Medicaid coverage, most of them have coverage through Original Medicare. However, some full dual beneficiaries may choose to enroll in a MA plan.

Some Medicare beneficiaries may qualify for the Medicare Savings Program called “Qualified Medicare Beneficiary,” or QMB. Similar to the full dual-eligible beneficiaries, those with QMB have lower out-of-pocket costs associated with their Medicare coverage, and most of them have coverage through Original Medicare. However, some QMBs may choose to enroll in a Medicare Advantage plan.

Both full duals and QMBs receive assistance from Medicaid to pay for certain costs associated with Medicare Advantage plans. These costs include:

- Medicare premiums
- Deductibles
- Coinsurance and copayments (except for Part D copayments)

Enrollment of full duals and QMBs into some Medicare Advantage (MA) plans can be problematic. Not all MA plans have a contract in place with the state Medicaid office. Without such a contract, payment to providers for services received by enrollees may not occur as it should. When these beneficiaries receive covered services from a provider, the provider bills the MA plan for the services. If the plan does not have a contract with Medicaid, the claim is not always submitted by the provider to Medicaid for payment. The provider then may end up billing the beneficiary for the copayment charges that, for other Medicare beneficiaries, would be associated with the service. **Many times beneficiaries pay out-of-pocket for these charges, not realizing that they are protected by law from being charged these cost-sharing amounts and that Medicaid should cover these costs.**

Marketing Overview – Medicare Advantage and Medicare Part D

The Centers for Medicare & Medicaid Services (CMS) has set Marketing Guidelines for Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). Providers, such as pharmacies and all other entities that contract with MA plans, must also follow a set of Marketing Guidelines. Congress took steps in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 to address several problematic marketing activities. MIPPA and related CMS rules and guidance deal with unsolicited contacts with Medicare beneficiaries, providing meals to prospective enrollees, and the use of unlicensed sales agents. CMS also issued new guidance on co-branding, appointments to market MA plans to prospective enrollees, and agent and broker compensation. The entire list of requirements is available at <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>.

It is important for SHICK counselors and Medicare beneficiaries to recognize and report to CMS activities or behaviors that do not meet the Marketing Guidelines.

Marketing for the next plan year may not begin until MA organizations and Medicare drug plan sponsors receive notice from CMS that they have an approved contract to offer in the coming year, but not before October 1 of the current year. Prior to this marketing period, plans may only provide educational material or presentations to eligible Medicare beneficiaries, that is, with no intent to enroll potential members.

Co-Branding with Providers or Downstream Entities

Plans are prohibited from displaying the names and/or logos of co-branded providers on the Plan's member identification card, unless the provider names and/or logos are related to a member's selection of a specific provider/provider organization, (e.g., physicians, hospitals). Part D Sponsors are prohibited from displaying the names and/or logos of co-branded providers/pharmacies on the Part D Sponsor's member identification card.

Plans/Part D Sponsors that choose to co-brand with providers/pharmacies must include on marketing materials (other than ID cards) the appropriate disclaimer. Neither the Plan/Part D Sponsor nor its co-branding providers/pharmacies, whether through marketing materials or other communications, may imply that the co-branding partner is endorsed by CMS, or that its products or services are Medicare-approved. Co-branded marketing materials must be submitted to CMS by the Plan/Part D Sponsor.

Cross-Selling

A CMS rule prohibits MA and Part D drug plans and their representatives from marketing non-health care related products (such as annuities and life insurance) to prospective plan enrollees during sales activities or presentations. The rule's purpose is to prevent confusion that Medicare health plans and non-health related financial products are part of the same package. Plans may, however, sell non-health related products on inbound calls when a beneficiary asks for information about them.

Marketing Materials

All materials used in promoting and selling a MA plan or a Medicare drug plan and for enrollment are subject to CMS rules and restrictions on marketing. Separate CMS rules govern the materials that plans use for different phases of the marketing process.

- Advertising
- Advertising, as governed by CMS rules, includes the following methods:
 - Television ads
 - Radio ads
 - Banner ads
 - Outdoor advertising
 - Print ads
 - Internet advertising
 - Direct mail (including enrollment forms or materials)

Pre-Enrollment Materials

CMS has a specific set of rules to govern the marketing materials that MA organizations and Medicare drug plans use prior to enrollment. These are called “pre-enrollment materials.”

Language Requirements

MA and Medicare drug plans must include certain statements in all pre-enrollment materials. These language requirements fall into the following specific categories:

- **Lock-In Statement/Access Information:** This statement must be used by MA plans that limit access to providers (i.e., a coordinated care plan’s provider network). Pre-enrollment materials must indicate that enrollees must use plan providers for routine care. These materials must state that neither Medicare nor the MA plan will cover routine care received outside of the plan’s network.
- **Benefit and Plan Premium Information:** Pre-enrollment materials must include the specifics of coverage and cost information, including:
 - Part B premium payment
 - Annual limits on benefits
 - Annual monetary limits
 - Major exclusions and limitations
 - Reference to the plan’s customer service phone number
- **Enrollment Limitations:** Sponsors must include a statement indicating that beneficiaries may enroll in a plan only during specific times of the year.
- **Network Limitations:** Medicare drug plans must explain the requirement that enrollees use network pharmacies, except under non-routine circumstances when they could not reasonably use network pharmacies.
- **Alternative Formats:** Pre-enrollment materials must indicate when a MA or Medicare Drug plan has beneficiary materials in alternative formats (e.g., Braille, languages other than English, audio, or large print).
- **Claim Forms and Paperwork:** Materials addressing claim forms and paperwork may not state the plan has “no paperwork” or “no claim forms,” but the materials may say, “virtually no paperwork” or “hardly any paperwork.”

Summary of Benefits

The Summary of Benefits (SB) is the main means that a MA organization or Medicare Drug Plan uses to provide current enrollees and eligible individuals wide-ranging information about a plan’s structure, coverage, benefits, and costs.

Initial Enrollment Period (IEP)

Generally, an individual becomes eligible for Medicare on the first day of the month of the individual's 65th birthday or the 25th month of disability. The three months before, the month during, and the three months after this eligibility date are known as the Part B Initial Enrollment Period (IEP). This time frame is also the IEP for Part D benefits. Beneficiaries who do not enroll in a Medicare drug plan during their IEP generally will not be able to enroll in a plan until the following annual Open Enrollment Period (OEP), unless they qualify for a special enrollment period, or SEP. Note that if a beneficiary does not have creditable drug coverage and does not enroll in a Medicare drug plan during the IEP, he will likely have a late enrollment penalty added to his Medicare drug plan's premium if and when he enrolls.

Initial enrollment for Medicare works differently for some people with disabilities. For those with end-stage renal disease (ESRD), beneficiaries must file a written application for those benefits when they become eligible. Those who have had a kidney transplant and those who have had kidney dialysis for three months are entitled to Medicare Part A. Part D eligibility begins upon entitlement to or enrollment in Medicare Part A and/or Part B. Thus, upon filing an application for Medicare Part A coverage, beneficiaries are entitled to enroll in a Part D plan.

Part D eligibility and enrollment for those with Lou Gehrig's disease (amyotrophic lateral sclerosis, ALS) is more similar to the process for those with disabilities. The 24-month waiting period that applies to most beneficiaries with disabilities does not apply to those with ALS. These individuals have a 5-month waiting period; their Part A coverage begins on the sixth month of the ALS disability. Thus, these beneficiaries have seven months of a Part D IEP. Their IEP begins in the second month of ALS disability and continues to three months past the month their Part A benefits begin.

Yearly Opportunity for Enrollment: AEP

Beneficiaries who already are enrolled in Medicare may enroll in a plan, change plans, or disenroll from their current plan during the annual Open Enrollment Period (OEP). The OEP runs from October 15 through December 7 each year. A decision to enroll or disenroll during the OEP is effective usually for the entire calendar year starting on January 1. Beneficiaries who make more than one enrollment choice during the OEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change their minds throughout the OEP. While this may be helpful for some individuals, keep in mind that other insurance sales agents can undo a plan selection made during an earlier SHICK counseling session with a client.

Special Enrollment Periods (SEPs)

Special Enrollment Periods (SEPs) enable Medicare beneficiaries to make Part D plan enrollment changes in special situations. Special enrollment periods constitute periods outside of the usual IEP for Part D or AEP when an individual may elect a plan or change his or her current plan election. There are various types of SEPs, including SEPs for dual-eligible individuals, for individuals whose current plan terminates, for individuals who change residence and for individuals who meet exceptional conditions.

Change in Residence

Beneficiaries have the right to a SEP under the four following circumstances related to a change in residence:

- Those with a change in permanent residence that places them outside of their Part D plan's service area
- Those with new Part D and/or MA plans available due to a change in permanent residence
- Those not eligible for Part D because they have been living outside of the U.S. and have returned to the U.S.
- Those not eligible for Part D because they were incarcerated (in jail) and are now released

This SEP has certain notice procedures. For people who notify their plan in advance of their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months. People may request for the effective date of this SEP enrollment to be up to three months after they notify their plan but not earlier than the date of the move.

There are other procedures for those who do not notify their plans of their moves. If the plan learns from CMS (or otherwise) that an enrollee has lived outside of the plan's service areas for more than six months, the enrollee's SEP begins upon discovery of that move and continues for two months after the move.

Dual-Eligible Beneficiaries and Upon Losing Dual-Eligibility

All dual-eligible beneficiaries (including those with both Medicare and Medicaid and those who are in Medicare Savings Programs) have a SEP that begins upon becoming dual-eligible and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from Part D plans, including PDPs and MA-PD plans, at any time. Beginning in 2019, the beneficiary will be limited to a onetime per calendar quarter election between January through September. The effective date of the change is the first of the month following the request for the change.

Contract Violation

Part D plan enrollees who demonstrate to CMS that the PDP sponsor violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another Part D plan. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS. CMS also may approve retroactive disenrollment in these cases, depending on the severity of the situation. In considering cases for retroactive disenrollment, CMS will consider certain factors in each case.

Non-Renewals or Terminations

Beneficiaries whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 to January 31 of the next year. In these circumstances, CMS requires these plans to give a 90-day notice to enrollees. The effective date of the enrollment may be on January 1, or February 1, but not before the plan receives the enrollment request.

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month past the termination effective date. These plans are required to give a 60-day notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

state law to execute the enrollment and that the documentary proof of such legal authority will be made available to CMS or the plan upon request.

SHICK counselors who assist Medicare beneficiaries with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. SHICK counselors who assist beneficiaries with Part D plan enrollment are merely facilitating the process. ***Counselors can avoid problems by making sure that they do not indicate that they represent their clients or sign enrollment forms on a client's behalf unless the client is unable to write.*** If clients are not able to write, counselors should follow the standard rules for such cases. This means that the client should make an "X" in the signature box and the witness should write "By" and his name and address with a short description of reason the patient cannot sign.

Disenrolling and Switching

Most Medicare beneficiaries who currently are enrolled in a Part D drug plan may only disenroll from that plan during certain periods: the OEP from October 15 through December 7, certain situations during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31, and applicable SEPs. Generally, once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year.

There are a few ways for a Medicare beneficiary to disenroll from a Part D plan:

- By enrolling in another plan
- By giving or faxing a signed written notice to the PDP sponsor
- By requesting disenrollment online to the PDP sponsor (if the sponsor offers this option)
- By calling 1-800-MEDICARE

Annual Open Enrollment Period (OEP)

During the OEP, Medicare beneficiaries can make only one choice among two options affecting their drug plan enrollment. They either can enroll in a different Part D plan (PDP or MA-PD) or disenroll from their current plan. Enrolling in a different Part D plan effectively switches the beneficiary from one plan to the other.

Medicare Advantage Open Enrollment Period (MA OEP)

A separate yearly disenrollment period for changes related to Medicare Advantage plans is called the Medicare Advantage Open Enrollment Period (MA OEP). It lasts from January 1 to March 31 each year. During the MA OEP, Medicare beneficiaries have an opportunity to change their Medicare Advantage plan coverage. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage. Any change made during the MA OEP takes effect on the first of the following month.

Special Enrollment Period (SEP)

During any applicable SEP, a beneficiary may disenroll from a Part D plan. Beneficiaries need only enroll in a new Part D plan to be disenrolled from a previous one. A disenrollment during the SEP does not prevent a beneficiary from subsequently enrolling in another plan as long as the SEP's timeframe has not expired. The length of an SEP varies according to the situation. People who move out of their drug plan's service area, for example, can have a SEP of up to four months. In contrast, people who move out of a certain type of nursing facility have a SEP that lasts up to two months after discharge.

MA Plans and Part D

Generally, Medicare beneficiaries who want drug coverage and the benefits of a Medicare Advantage plan must select an MA plan that offers Part D prescription drug coverage (MA-PD). This rule is absolute for all coordinated care plans (i.e., HMOs, PPOs, and SNPs). Those beneficiaries enrolled in coordinated care plans who want Part D coverage must enroll in coordinated care plans that have a Part D component—an MA-PD plan. This means that enrollees in coordinated care plans without Part D coverage—MA-only plans—will not have access to drug coverage through Medicare. Furthermore, Special Needs Plans (SNPs) must provide Part D coverage. Thus, all SNPs are MA-PDs, and enrollees have access to Medicare drug coverage through their SNPs.

An exception applies to beneficiaries who are enrolled in certain types of MA plans that do not provide drug coverage, including some PFFS plans and all Medical Savings Account (MSA) plans. Private Fee-for-Service plans may or may not have Part D coverage. For those PFFS plans that are MA-PDs, enrollees must take the Part D coverage that comes with the plan. For those PFFS plans that do not offer drug coverage, enrollees may also enroll in stand-alone Prescription Drug Plans (PDPs) to receive Part D coverage. Additionally, MSA plans are not permitted to offer drug coverage, so enrollees in these plans also may enroll in stand-alone PDP plans.

Costs and Prices

Beneficiaries enrolled in both types of Part D plans—PDPs and MA-PDs—will have costs associated with enrollment in those plans. The costs will differ from beneficiary to beneficiary and from plan to plan.

Those who qualify for the low-income subsidy (LIS) receive assistance from Medicare to help cover some or all of these costs that others pay out-of-pocket. ***Throughout this section, for the sake of simplicity, the costs and prices discussed will apply to those beneficiaries who do not qualify for LIS.***

Beneficiary Cost-Sharing

Beneficiaries who are enrolled in Part D plans almost always have cost-sharing responsibilities. These costs generally include the monthly premium, an annual deductible, and copayments or coinsurance for each prescription filled. Above a certain level of out-of-pocket spending, beneficiaries also will have costs in the coverage gap, also known as the “donut hole.” Once beneficiaries have spent to another set level, costs are minimal as there is a level of catastrophic coverage in the Part D plan design.

Monthly Premiums

A premium is a set amount of money beneficiaries must pay each month to a Part D plan in order to be enrolled in a plan. Monthly premium amounts range widely. Plans with higher premiums sometimes offer enhanced benefits, such as a broader formulary with more access to brand-name medications or coverage for some drugs in the coverage gap.

Beneficiaries have several options to pay the monthly premium to their plan. They can choose to pay the premium directly to the plan by check, money order, a savings or checking account deduction, or electronic payment by phone or through the Internet by using credit cards. Beneficiaries may also elect to have the premium deducted from their Social Security checks. ***Data transfers from the drug plans to CMS and then to SSA can take a few months to process, which can result in up to three months of premiums taken out of a Social Security check at once.***

IRMAA (Income Related Medicare Adjustment Amount) Beginning 2011, the Affordable Care Act required Part D enrollees whose incomes exceed the same thresholds that apply to Part B enrollees to pay an income-related monthly adjustment amount, in addition to their Part D plan premium.¹

Annual Deductible

A deductible is the amount a beneficiary owes out-of-pocket before the drug plan starts to pay for medications on its formulary. The allowed deductible amount increases each year. Plan deductibles range from \$0 to an amount which changes each year, depending on the type of plan. Some plans have a structure in which certain tiers of their formularies are exempt from the deductible. For example, a plan could allow enrollees to pay reduced cost-sharing for generic drugs, but brand-name drugs are full price until the enrollee reaches the deductible.

Copayments and Coinsurance Amounts

After plan enrollees spend the full amount of a plan's deductible, they enter the period of coverage known as the "initial coverage period." During the initial coverage period, Part D plans charge either a copayment or coinsurance amount for each medication that enrollees fill at pharmacies. Each plan sponsor sets the copayment or coinsurance amount, and the amount differs according to the drug plan's design. Typically, beneficiaries pay this out-of-pocket cost at the time they receive each filled prescription.

Copayments are a flat-rate amount, such as \$5 or \$25, charged to beneficiaries for each prescription. Coinsurance charges are based on a percentage of the total negotiated price of a prescription, such as 25% (as in the case of a basic standard plan). Negotiated prices are the costs for prescription drugs agreed upon through direct negotiation between the Part D sponsor or an intermediary contracting organization, such as a pharmacy benefit manager (PBM), and the pharmaceutical manufacturer. In effect, the negotiated price is the amount paid by Part D plans to pharmacies for each prescription drug filled by a plan enrollee.

True Out-of-Pocket (TrOOP) Costs

True Out-of-Pocket (TrOOP) costs are those that a beneficiary incurs in the course of paying the cost-sharing amounts for covered drugs under a Medicare Part D drug plan. Plans calculate these costs for each enrollee in order to determine which level of coverage to provide (i.e., deductible, initial coverage period, coverage gap, or catastrophic coverage). TrOOP includes the total amount of any annual deductible paid plus the price paid for each formulary prescription filled. ***Note that the monthly premium does not count towards TrOOP costs.***

It is important for SHICK counselors to understand the relationship between TrOOP costs and the initial coverage limit and catastrophic coverage. As beneficiaries incur costs under their Part D plans, they move closer to the initial coverage limit.

After plan enrollees reach the initial coverage limit measured by total drug spending, they enter the coverage level known as the coverage gap. During the coverage gap, beneficiaries must pay the negotiated price for covered drugs minus a discount on brand name drugs or generics.

Important Note about TrOOP:

The total amount spent in the gap on plan-covered drug costs includes: the drug costs paid by the beneficiary and the discount on brand-name drugs paid by the drug manufacturer.

¹ Annual cost-sharing amounts are available in the appendix under *Annual Medicare Premium and Cost-Sharing Amounts*.

The remaining discount paid by the Part D plan for covered-brand name drugs and the discount on covered-generic drugs while in the Coverage Gap do not count toward TrOOP.

When the amount spent on Plan-covered drugs reaches the catastrophic limit, the beneficiary reaches the catastrophic coverage threshold. Beneficiaries with catastrophic coverage pay the greater of five percent of the plans' negotiated drug costs or lower copayments for generics and preferred brand-name drugs and a higher copayment for other brand-name drugs for the remainder of the calendar year. The Part D plan covers 95% or the balance of the cost.

Beneficiaries with LIS also incur TrOOP costs. Their TrOOP includes the amount Medicare pays for formulary drugs for LIS beneficiaries in Part D plans. For those with LIS, Part D plans use TrOOP to determine the point when beneficiaries enter catastrophic coverage. The catastrophic limit is the same for all enrollees in Part D plans.

A plan must send a statement, called an "Explanation of Benefits" (EOB), to every enrollee at the end of each month showing how much the plan and the enrollee have paid in TrOOP costs. Part D plans are responsible for calculating and reporting TrOOP costs.

TrOOP costs for each Part D enrollee follow enrollees throughout the plan year. If a beneficiary switches Part D plans, his TrOOP costs are transferred to the new Part D plan. For this reason, beneficiaries cannot switch Part D plans to "reset" their TrOOP costs and avoid the coverage gap. Because TrOOP follows Part D enrollees from plan to plan, there is no way to "game the system."

Certain out-of-pocket expenses count towards TrOOP costs, and other out-of-pocket spending does not count.

TrOOP Includes	TrOOP Does NOT Include
Out-of-pocket expenses including the annual deductible and all coinsurance and copayment amounts for drugs on the plan's formulary	Monthly premiums paid to the plan
Spending from health savings accounts (HSAs), flexible spending accounts (FSAs), and medical savings accounts (MSAs)	Amount paid by other insurance plans in addition to the beneficiary's Part D coverage (e.g., an employer or retiree group plan's drug benefit, VA, or TRICARE)
Contributions or payments for drugs on the plan's formulary paid by friends or relatives on a beneficiary's behalf	Amount paid by Medicaid or by state programs that receive federal or public funds
Contributions or payments for drugs on the plan's formulary paid by certain charitable foundations on a beneficiary's behalf	Amount spent for prescription drugs that are non-Part D drugs or that are not on the plan's formulary (unless the enrollee received a formulary exception for a drug)
Unadvertised, individualized waivers or reductions of plan cost-sharing amounts by pharmacies due to a beneficiary's inability to pay	Amount spent for prescription drugs that are purchased from a pharmacy that is not in the pharmacy network of the plan (except for drugs received due to a plan's out-of-network policy)
Payments by Qualified State Pharmaceutical Assistance Programs (SPAPs)* (not available in Kansas)	Total cost of a drug that a private Patient Assistance Program (PAP) provides to a beneficiary

Original Medicare Coverage Decision Notices

As you work with clients, be aware of these four kinds of coverage and payment notices in Original Medicare. All notices contain information about the next step that a beneficiary can take to request a coverage decision or appeal. The next steps may vary, depending on the notice.

- **Medicare Summary Notices (MSN)**

After a provider, like a home health agency, physician, or ambulance company, submits a claim for payment to Medicare, the MAC makes a coverage and payment decision detailed in an MSN. The MSN is Medicare's official "initial determination" on a claim for coverage and payment. Medicare sends MSNs to beneficiaries every three months. If the MSN shows that Medicare denied coverage and payment, the beneficiary, her representative, or the provider can look to the instructions on the MSN to request a redetermination.

- **Inpatient Hospital Notices**

Acute care hospitals issue *An Important Message from Medicare about Your Rights (IM)* to all Medicare patients at the time of admission, and may reissue the *IM* before the patient's discharge. If a beneficiary disagrees with the proposed discharge, they can ask the BFCC-QIO to make an expedited determination of the need for a longer hospital stay. Soon after a beneficiary makes this request, the hospital must deliver a *Detailed Notice of Discharge (DND)*.

- **Service Termination Notices**

Skilled nursing facilities (SNFs), home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), and hospices must give written notice to beneficiaries before they end Medicare-covered services or discharge a beneficiary from their care. This standard notice of a decision to terminate services is called a *Notice of Medicare Provider Non-Coverage*. This notice is not an official initial determination or Medicare coverage decision. It merely states the provider's opinion that the beneficiary no longer meets Medicare's coverage rules for the service. This notice must give the:

- Patient at least two days' notice of the proposed end of services.
- Date that coverage of services ends.
- Date that the beneficiary's financial liability for continued services starts.
- Notice of the right to an expedited determination by the Quality Improvement Organization (QIO).

- **Advance Beneficiary Notices (ABN)**

Medicare Part A and Part B health care providers may issue ABNs. CMS has a general ABN for use by physicians, DME suppliers, laboratories, and hospices. Home health agencies and skilled nursing facilities use other ABNs. Because ABNs are not official Medicare coverage determinations, there is nothing to appeal unless the provider submits a claim. After receiving an ABN, a patient has the right to ask a provider to submit a claim to Medicare. If the Medicare payment contractor then issues an MSN showing that it denied payment on the claim for lack of medical necessity, a beneficiary can start the appeal process by requesting a redetermination.

The Appeals Process – Original Medicare

Level 1: Redetermination

The beneficiary, a representative, or a physician must send a written request for a redetermination to the MAC within 120 days of receiving the MSN with its denial notice. Those with good cause can request an

extension. The written request can take the form of a letter, a copy of the MSN with the words “Please Review” written on it, or a CMS *Redetermination Request* form.

In the redetermination process, a person who was not involved in the initial decision reviews the claim for improper coding, missing documentation, and additional information from the provider or patient. Redetermination notices explain the facts, policies, and law that underlie the Medicare payment contractor’s redetermination decision. The MAC has 60 days to make its redetermination decision.

Level 2: Reconsideration

The deadline for filing a request for reconsideration is 180 days after receipt of the MAC’s adverse redetermination decision. Those with good cause can ask for an extension.

You can send a *Reconsideration Request* to the Qualified Independent Contractor (QIC) named on the redetermination notice. CMS contracts with four regional QICs for Part A and Part B, and a national QIC for Durable Medical Equipment, Prosthetic, and Supply (DMEPOS) appeals. The QICs are:

- Part A west region: Maximus Federal Services, Inc., <http://www.medicarepartaappeals.com/>
- Part A east region: Maximus Federal Services, Inc., <http://www.medicarepartaappeals.com/>
- Part B north region: C2C Solutions, Inc., www.c2cinc.com/QICPartBNorth.aspx
- Part B south region: Q2A Administrators, LLC., <http://www.q2a.com>
- DMEPOS-National: [C2C Solutions, Inc., www.c2cinc.com/QICDME.aspx](http://www.c2cinc.com/QICDME.aspx)

In its reconsideration, the QIC conducts a review of the medical record in light of CMS manual guidelines and coverage determinations. There is no face-to-face meeting with a decision maker at this stage. The QIC must issue a written reconsideration decision, explaining its rationale, within 60 days.

Level 3: ALJ Hearings

A beneficiary, a beneficiary’s representative, or a physician who receives an unfavorable reconsidered determination from the QIC has a right to a hearing with an Administrative Law Judge (ALJ) if a minimum amount of money is at stake. The amount in controversy is the amount of money involved with the denied services. In other words, the amount in controversy is the total projected value of the denied services or benefits. Enrollees having more than one denied claim may combine their claims to meet the threshold amount in controversy, if needed, as long as all of the claims have followed the proper procedures.

Beneficiaries (or the representative or physician) may request an ALJ hearing only in writing and according to the instructions found in the QIC’s reconsideration notice. The request for an ALJ hearing must be made within 60 days of notice of the QIC’s unfavorable reconsidered determination. As with requests for reconsideration, those with good cause may be granted an extension past this 60-day time frame.

Most ALJ hearings take place using video-teleconferencing (VTC) facilities. The ALJ hearing is a beneficiary’s first chance to meet face-to-face (to the extent that VTC technology allows) with a decision-maker. It provides a chance to ask and answer questions, and to bring in witnesses, such as a physician.

Administrative Law Judges work for the Office of Medicare Hearings and Appeals (OMHA). Like CMS, OMHA is an agency within the federal department of Health and Human Services. For more information about ALJ hearings, including relevant forms, internal procedures, and FAQs, visit OMHA’s website at <http://www.hhs.gov/omha/index.html>.

Level 4: Medicare Appeals Council (MAC) Review

Any of the relevant parties who disagree with an adverse ALJ hearing decision (including case dismissal) may ask the Medicare Appeals Council (MAC) to review the case. The MAC has the option to grant or decline each request for review. In response to each case, the MAC may issue a final decision or a dismissal, or return the case to the ALJ with instructions. The MAC may initiate its own review of any ALJ hearing decision or dismissal. When it does so, the MAC must notify all relevant parties.

Beneficiaries, their representatives, physicians, or CMS may request MAC review only in writing. If CMS requests the MAC review, it must provide notice to the beneficiary. The request for a MAC review must be made within 60 days of receipt of the ALJ hearing decision or dismissal. As with other steps in the appeals process, those with good cause may be granted an extension past this 60-day time frame.

The MAC uses the following criteria to either grant or decline cases submitted for review:

- Does there appear to be an abuse of discretion by the ALJ?
- Is there an error of law?
- Are the actions, findings, or conclusions of the ALJ not supported by substantial evidence?
- Is there a broad policy or procedural issue that may affect the general public interest?

Level 5: Judicial Review

Any of the relevant parties who disagree with a hearing decision (including case dismissal) may request a federal district court to review the ALJ decision if the MAC declined to review the case or affirmed an adverse ALJ decision, and if the amount in controversy is a minimum amount.

To start the judicial review process, the relevant party must file a civil action in a district court in the judicial district where the beneficiary lives.

Expedited Determinations and Reconsideration in Original Medicare***Right to an Expedited Determination***

If a beneficiary receives a *Notice of Medicare Provider Non-Coverage* service termination notice from a home health agency, hospice, skilled nursing facility, or Comprehensive Outpatient Rehabilitation Facility (CORF), they have a right to an expedited determination by the Medicare Quality Improvement Organization (QIO). In Kansas, the Beneficiary and Family Centered Care (BFCC)-QIO is KEPRO - <https://www.keproqio.com/>, 1-855-408-8557.

Expedited Determination Procedures

A beneficiary must ask the BFCC-QIO for an expedited determination, by telephone or in writing, by noon of the day following receipt of the provider's service termination notice. The *Notice of Medicare Provider Non-Coverage* has instructions on how to reach the BFCC-QIO. The beneficiary or her representative must be available to answer questions for, or provide information to, the BFCC-QIO staff. The beneficiary may submit evidence to the BFCC-QIO.

When it makes an expedited determination about a provider's decision to terminate services, the BFCC-QIO:

- Must immediately notify the provider about the request.
- Determines if the termination notice is valid.
- Examines the medical record and determines if a physician certified that a significant health risk exists for the patient.

- Must seek the beneficiary's views.
- Gives the provider a chance to explain why the termination or discharge is appropriate.
- Notifies the beneficiary, her physician, and the provider of its decision generally within two days of receiving the expedited determination request.
- May initially notify the parties by telephone but must follow up with a written notice. The notice must give the date on which the beneficiary becomes liable for the cost of continued services, and describe her right to an expedited reconsideration.

When a beneficiary requests an expedited determination, Medicare coverage continues until the BFCC-QIO completes the determination process. A provider may not bill the beneficiary for the disputed services until then. If the patient decides to pay for ongoing care after coverage termination, they can ask the provider to submit a claim to Medicare. This is called a "demand bill." If Medicare denies payment, the patient can request a redetermination.

Inpatient Hospital Notices and Expedited Procedures

An acute care hospital must give *An Important Message from Medicare about Your Rights (IM)* to all Medicare patients at the time of admission and again no later than two days before a proposed discharge. The *IM* describes a beneficiary's right to an independent review when they disagree with a proposed discharge. If a beneficiary disagrees with a hospital's discharge decision, he or someone on his behalf should call the BFCC-QIO no later than the planned discharge date to request a quick review.

Instructions for this process and the BFCC-QIO's toll-free phone number should appear on the Important Message from Medicare. After a person requests the BFCC-QIO review, the hospital must give the patient a *Detailed Notice of Discharge* that contains specific information about the Medicare coverage policies upon which the hospital has based its decision.

To receive an official expedited coverage determination, the patient must call the BFCC-QIO no later than noon of the proposed day of discharge. Medicare requires the BFCC-QIO to issue a written decision within one day of receiving all the information it needs to make a decision. If the QIO decides that the patient is ready to be discharged, Medicare covers the hospital stay until noon of the day after the BFCC-QIO gives notice of its decision.

If the patient disagrees with the BFCC-QIO's decision, he may request expedited reconsideration of the BFCC-QIO's decision by noon of the next calendar (not working) day. The Qualified Independent Contractor (QIC) reviews the case and issues a decision within 72 hours.

Medicare Advantage Grievances and Appeals

All Medicare beneficiaries enrolled in Medicare Advantage (MA) plans have the right to a review of adverse coverage decisions that the plans make regarding health services. Thus, all organizations offering MA plans must have procedures in place for enrollees to exercise their rights. These rights fall into three main categories:

- **Grievance:** A complaint or dispute that describes an enrollee's dissatisfaction with the way the MA plan provides health care services, regardless of whether a remedy exists.
- **Organization Determination:** A determination an MA plan makes regarding
 - Payment for certain out-of-network services received by an enrollee
 - Payment for health services the enrollee believes are Medicare-covered

You should also include any other information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

Your plan will respond to your request for an appeal within the timeframes below:

- Standard service request—30 days
- Payment request—60 days
- Fast request—72 hours

Your request will be a fast request if your plan determines, or your doctor tells your plan, that your life or health may be at risk by waiting for a standard decision.

The timeframe for completing standard service and fast requests may be extended by up to 14 days. The timeframe may be extended if, for example, your plan needs more information to make a decision about the case, and the extension is in your best interest.

If the plan decides against you (fully or partially), your appeal is automatically sent to level 2.

Level 2: Part C Qualified Independent Contractor and Reconsidered Determinations

The Independent Review Entity (IRE) that reviews MA plans' unfavorable reconsideration decisions is called a Qualified Independent Contractor (QIC). Maximus Federal Services (formerly Maximus CHDR-Center for Health Dispute Resolutions) is the QIC under contract with CMS to review Medicare Advantage coverage and payment denials. It issues a "reconsidered determination" at this second level in the Medicare Advantage appeals process. In conducting its review, Maximus refers to Medicare coverage policies and to its own Medicare Advantage Reconsideration Process Manual. Once an MA plan forwards its unfavorable reconsideration decision to Maximus, the QIC must adhere to the same time frames established for MA plan reconsiderations, whether standard or expedited.

Maximus must notify all relevant parties (including the enrollee, any representative, the physician, and the MA plan) of the decision it makes. The decision notice must:

- Be written in understandable language
- Be written in a manner that takes into account the medical conditions, disabilities, and special language needs of the enrollee
- Provide the reasoning for the decision
- Provide information about the next step in the appeals process (i.e., the ALJ hearing), in the case of an adverse decision and if the amount in controversy is met (see below)

If Maximus reverses the MA plan's coverage denial under standard review procedures, the plan must authorize or provide the service as soon as the enrollee's health requires, but not later than 14 days from the date the plan receives notice from Maximus that it reversed the plan's reconsidered decision. If instead Maximus reverses the MA plan's coverage denial under expedited review procedures, the plan must authorize or provide the services to the enrollee as soon as the enrollee's health requires, but not later than 72 hours from the date the plan receives notice from Maximus that it reversed the plan's reconsidered decision. Finally, if Maximus reverses an MA plan's reconsidered decision to deny a payment request, the plan must pay for the services no later than 30 days from the date it receives notice of the reversal.

Quality Improvement Organizations (QIO)

When an MA plan terminates coverage of an inpatient hospital stay, or when the plan or a contracting provider terminates pre-authorized skilled nursing facility (SNF), home health agency, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, a special expedited review procedure exists. An IRE known as a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), under contract with CMS to review quality of care issues, performs the specialized review. The BFCC-QIO review procedure bypasses the MA plan's reconsideration process (described above) when an appeal request to the BFCC-QIO meets a tight deadline. For information on the BFCC-QIO in your state, beneficiaries can either check the coverage termination notice or call 1-800-MEDICARE.

When an SNF, home health agency, or CORF believes that the care it is currently providing to an MA plan enrollee no longer meets Medicare coverage criteria, it often will give a Notice of Medicare Non-Coverage to the person. SNF, HHA, and CORF service providers must deliver the notice to the enrollee, on the MA plan's behalf, at least two days before the termination of services. Valid delivery means that the enrollee must be able to understand the notice's purpose in order to sign for receipt of it. Other notice protections apply to incompetent persons in institutions.

The NOMNC gives an ending date for the services and has instructions on how to ask the QIO for an immediate appeal. The key to this special review procedure is to make the review request—by calling the BFCC-QIO—as soon as possible, but no later than noon of the day before the service termination is due to take effect. The NOMNC must contain the BFCC-QIO's name and phone number. The notice also informs the enrollee that they may have to pay for services after the termination date if the BFCC-QIO agrees that Medicare no longer covers the services. If a person misses the deadline for requesting an immediate appeal with the BFCC-QIO, they may still ask her MA plan for an expedited reconsideration.

Level 3 through Level 5

The last three levels of Appeal for Medicare Advantage Plans are the same as for Original Medicare. (See page 8-13 for more details.)

Giving Effect to Decisions from ALJ, MAC, and Judicial Review

If an ALJ, the MAC, or a federal court reverses an MA plan's coverage or payment denial, the MA plan must authorize, provide payment for, or provide the service as soon as the enrollee's health requires, but not later than 60 days from the date the plan receives notice of the decision to reverse the plan's original decision.

Part D Grievances, Coverage Determinations, and Appeals

Because each Medicare drug plan has a different formulary, as well as different rules regarding access to drugs, some enrollees may have problems getting all of their prescriptions filled through their Part D plans. The MMA establishes specific rules and processes for beneficiaries who are having difficulty obtaining their prescriptions. Understanding the reasons for the plan's denial of coverage and learning what to do about it are important steps in obtaining a drug from the Part D plan.

Grievances

All Medicare drug plans must have processes in place to hear and resolve grievances filed by Part D plan enrollees. Here are several examples of situations that Part D plans should process as grievances:

- Complaints about copayment amounts

Exclusion

Under exclusion, Medicare benefits are subtracted from the total that the plan would pay and employer-sponsored plan benefits are calculated on the remainder.

Example: Company determines amount plan would pay without Medicare:

\$800.00

Subtract the amount paid by Medicare: -800.00

Plan pays the difference: -0-

Coordination of Benefits

Under coordination of benefits, the plan pays the difference between Medicare payments and the actual charges, up to the amount the plan would have paid in the absence of Medicare.

Example: Plan looks at balance after Medicare pays: \$200.00

Plan compares that with the amount it would

Pay without Medicare: \$800.00

Plan pays the lesser amount: \$200.00

Federal Retirement Insurance

Federal health insurance can be continued for federal government employees when they retire. This insurance is secondary to Medicare. The federal government offers over 100 different plans (including managed care plans) to different types of federal workers.

Also, for these retirees ONLY, Medicare Part B may not be as critical even for fee-for-service plan enrollees and is NOT required.

For enrollment questions, contact the **U.S. Office of Personnel Management**, Health Benefits Branch, **1-888-767-6738**.

State Retirement Insurance

If a state employee meets the retirement guidelines set by the State of Kansas, he/she may continue the coverage after retirement by paying the required premium.

State Employees with Medicare and State Retirees should look to the Department of Health and Environment, Division of Health Care Finance, for guidance in coordinating Medicare and their state insurance coverage.

They can be contacted at: 785-296-1715 OR Visit their website at: <http://www.kdheks.gov/hcf/sehp>

Special Considerations

If a retiree has an employer-sponsored plan available, it can be his or her best option. However, because some companies have reduced the coverage offered retirees and this trend is expected to continue, this source of supplemental insurance is not secure.

People with Medicare need to compare their employer's health insurance with a standard Medigap policy. Only one will be needed: a Medigap policy or an employer-sponsored plan.

ASK THESE QUESTIONS:

- ✓ Is the employer stable, or is the plan likely to be terminated or benefits cut due to financial pressures on the employer?
- ✓ Does the plan have a low lifetime maximum benefit? If so, how much has been used?
- ✓ Does the plan have an open enrollment period?
- ✓ Does the plan require the retired person to use only certain providers in a limited geographical area; can the retired person take the benefit along if he/she decides to move to a different part of the state or country?

Private Insurance***Specific-Disease Policy***

A specific disease policy provides coverage only for the specific disease or diseases named in the policy. A common type is cancer insurance. This type of plan does not provide basic health coverage.

These policies generally pay a fixed dollar amount for each day of hospitalization or outpatient treatment for the specified disease. Some policies help pay for certain surgical procedures or provide a first-occurrence payment if the insured is diagnosed with the covered disease.

The coverage is in addition to Medicare coverage. Cancer policies may cover some expenses not approved by Medicare. For example, some policies provide coverage such as transportation, food, and lodging costs. There is no standardization of specific-disease policies. Since coverage varies widely, premium costs also vary widely.

For a cancer policy, there is only a ten day “free look” period. Review the policy carefully. It is important for the policyholder to weigh the costs against the benefits. The value of the specific-disease policy depends on the chance that the insured will get the disease(s) the policy covers.

Hospital Indemnity Policies

A hospital indemnity policy pays a fixed dollar amount directly to the policyholder, such as \$100, for each day of hospitalization. There are several drawbacks. It pays only if the insured is hospitalized, and it does not provide protection against large medical bills outside the hospital stay. Amounts paid usually are a small percentage of the policyholder’s costs, and the fixed payments often do not keep pace with inflation. There are restrictions on when the coverage begins and a maximum amount the policy pays.

Amounts paid are in addition to what is paid by other insurance, and the money can be spent in any way. However, it is no substitute for a comprehensive Medicare coverage and should only be considered when the individual already has good general health coverage and can afford the additional cost each month.

Long-Term Care Policies

This type of coverage as well as other financial options to pay for all types of long-term care expenses is addressed in detail in Chapter 10 of this Handbook.

TRICARE for Life & TRICARE Senior Pharmacy

TRICARE is a health benefits program for all seven uniformed services: The Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. It provides medical, dental, and hospital benefits for dependents of active duty service personnel, and for retired service personnel and their dependents prior to age 65. Previously, at age 65 they become eligible for Medicare and their TRICARE benefits end. The spouse or dependent of a person who has turned 65, but who is not yet 65 him/herself, is eligible for TRICARE benefits, and may continue under this plan until age 65.

“This Act extends TRICARE health care and pharmacy benefits to Medicare-eligible retirees of the Uniformed Services, their families’ members and survivors. Under the law, pharmacy benefits are effective on April 1, 2001, and the rest of TRICARE health care benefits are effective on October 1, 2001” – from the Office of the Assistant Secretary of Defense Health Affairs

Medical Benefits

Effective October 1, 2001; all Medicare-eligible military beneficiaries became eligible for TFL benefits. The law requires that **ALL** Medicare-eligible beneficiaries, regardless of age, **MUST** be enrolled in Medicare Part B to receive these benefits.

How does TFL coordinate with Medicare?

- Services covered by both Medicare and TRICARE - Medicare will pay the provider, and then TFL will pay the Medicare deductible and copayment. Nationwide, 93% of providers accept Medicare, so this will cover the vast majority of cases.
- Services covered by Medicare but not TRICARE – The beneficiary will be liable for Medicare copayments, but (by law) the provider’s charges cannot exceed 115% of the Medicare Approved Amount. For example, a Medicare procedure not covered by TRICARE is Medicare’s limited chiropractic care benefit. In such a case, Medicare would pay 80% of the bill or the Medicare Approved Amount, whichever is less. The beneficiary would pay the remaining 20% copayment plus the 15% in excess charges, if any.
- Service covered by neither Medicare nor TRICARE. The beneficiary is responsible for the cost of non-covered services, e.g., routine dental care, hearing aids, eyeglasses and long-term custodial care.
- Services by TRICARE but not Medicare. The beneficiary is responsible for paying the standard TRICARE copayments. The new annual retiree family catastrophic cap (CATCAP) limits their maximum out-of-pocket cost for TRICARE-allowable medical expenses in any fiscal year to \$3,000. If the beneficiary has met the amounts for TRICARE deductibles and copayments, TRICARE will pay 100% of allowable charges for the rest of that fiscal year.

There are five main situations when TRICARE covers a service that Medicare does not:

- Prescription Drugs - see the TRICARE Senior Pharmacy (TSRx) Program
- Inpatient hospitalization when the Medicare benefit is exhausted - from the 151st day on, TFL becomes the first payer indefinitely. The beneficiary pays a 20% copayment when using TRICARE network hospitals and 25% when using non-network hospitals. If the beneficiary pays \$3,000 in family TRICARE

deductibles and copayments, TRICARE's CATCAP protection kicks in and TFL pays 100% of TRICARE-allowable costs for the remainder of the fiscal year.

- Skilled Nursing (Facility) Care without at least 3 days prior hospitalization. TRICARE becomes the primary payer and pays 75% of allowable charges. The beneficiary pays the TRICARE deductible and copayments of 25%, up to the annual \$3,000 CATCAP.
- Care for individuals residing in foreign countries. Medicare-eligible beneficiaries living in foreign countries still must enroll in Medicare Part B to use TFL. TRICARE will be the first payer for all covered services. In this case, you pay the \$150 annual TRICARE deductible (\$300 per family) plus 25% copayments, up to the \$3,000 CATCAP, plus any excess charges over the TRICARE-allowed amount.

Did you know? "Dual-eligible" is the term used to describe a TRICARE beneficiary who is entitled to Medicare.

Myth: TFL is only for TRICARE beneficiaries who are 65 years of age or older.

Fact: TFL is for all TRICARE beneficiaries who are entitled to Medicare because of a disability, end stage renal disease, or age.

See the TFL website for more detailed information - <http://www.tricare.mil>

Pharmacy Benefits - Tricare Senior Pharmacy (TSRx)

Effective April 1, 2001 - TRICARE beneficiaries who are 65 and over are receiving the same pharmacy benefit as retirees who are under 65. This includes access to prescription drugs not only at military treatment facilities, but also at retail pharmacies and through the Department of Defense national mail service program. TRICARE Senior Pharmacy & the Medicare Part D Prescription Drug coverage do coordinate - The TRICARE Drug benefit is CREDITABLE COVERAGE.

- If the beneficiary was 65 prior to April 1, 2001, the law states they automatically qualified for the benefit whether or not they had purchased Medicare Part B.
- If the beneficiary turns 65 after April 1, 2001, the law mandates that they **MUST** be enrolled in Medicare Part B to receive the TRICARE pharmacy benefit.

Retirees with questions? Call 1-877-DOD-MEDS (1-877-363-6337) OR <http://www.tricare.mil/pharmacy>

CHAMPVA

CHAMPVA, Civilian Health and Medical Program of the Department of Veterans Affairs, is a federal health benefits program administered by the Department of Veterans Affairs. CHAMPVA is a Fee-for-Service (indemnity plan) program. It provides reimbursement for most medical expenses - inpatient, outpatient, mental health, prescription medication, skilled nursing care, and durable medical equipment (DME). There is a very limited adjunct dental benefit that requires preauthorization.

CHAMPVA bases its benefit structure on the CHAMPUS/TRICARE Standard option. There are **no other** ties between the programs. CHAMPVA is administered by the Department of Veterans Affairs Health Administration Center in Denver, Colorado and is **only** for family members of 100% permanently and totally disabled veterans (not retired).

Who is Eligible for CHAMPVA?

Who is eligible for CHAMPVA:

- When a reservist is on active duty or active duty for training

Chapter 11

MEDICAID AND OTHER ASSISTANCE

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MEDICAID AND OTHER ASSISTANCE

This chapter is a brief summary of the rules, laws, and eligibility guidelines for Medicaid and other assistance programs. As a SHICK Counselor, you are not responsible for determining if a client is or is not eligible for assistance, **nor should you even hint at giving legal or financial advice.**

This information is intended to increase your awareness and understanding of programs for which a client might qualify and appropriate referral agencies to which a client may be directed.

Some clients will be reluctant to discuss financial matters or to deal with certain bureaucratic agencies. As a SHICK Counselor, you do not have the right to discuss a client's situation with anyone without the client's permission.

Medicaid

Medicaid is the name of the health care program for people receiving TAF (Temporary Assistance for Families) and certain low-income people who are also blind, aged, or disabled. It is a joint federal-state medical assistance program. It's a program that pays medical bills for low-income people who can't afford the costs of medical care. Medicaid pays benefits for covered services only when they are medically necessary.

Medicaid is a Federal program but is state regulated. All states must provide medical services to certain low-income people who are also blind, aged, or disabled. These services are mandated under federal law. Since it is a joint federal-state medical assistance program that pays medical bills for low-income people who can't afford the costs of medical care, states may provide other services in addition to those mandated.

What is KanCare?

The KanCare program is the State of Kansas' Medicaid program. KanCare delivers whole-person, integrated care for the more than 360,000 consumers receiving services. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare program began in January 2013. The KanCare health plans are Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (United).

The administration of KanCare within the State of Kansas is carried out by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS). KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for Disability Services, Mental Health and Substance Abuse, and State Hospitals and Institutions.

Each Medicaid consumer is assigned to one of the KanCare health plans. Consumers in KanCare receives all the same services provided under the previous Medicaid delivery system, plus additional services. However, services provided through the Home and Community Based Services waiver for consumers with intellectual or developmental disabilities (I/DD) were delayed for one year and became part of KanCare in February 2014. In addition to the services that were available to Medicaid consumers prior to 2013, the three health plans offer new services to their members, such as preventative dental care for adults, heart/lung transplants, and bariatric surgery.

During their transition to KanCare, consumers had the option to change to a different KanCare health plan if they prefer to do so. Consumers are with their health plan for one year. Consumers can change to a different plan annually during an open enrollment period beginning with their anniversary date.

All pre-2013 Medicaid services are provided through the KanCare health plans. These include physical health services such as doctors' appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, and nursing facility care. All the services offered through the State's Home and Community Based Services waivers will also be in KanCare. The HealthWave and HealthConnect Kansas programs have ended, and all of those services are now provided through the KanCare health plans.

The KanCare health plans are required to coordinate all of the care a consumer receives. The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. The health plans focus on ensuring consumers receive the preventive services and screenings they need, helping consumers manage their chronic conditions, and reducing unnecessary and duplicative services.

From www.KanCare.ks.gov

Medicaid Eligibility

Medicaid is for 1) people receiving TAF and 2) the aged (65 and older), blind, and disabled. There are limits on the amount of assets (resources) and income which an individual can have in order to be eligible for Medicaid. Unlike Medicare, Medicaid does not require that the applicant earn work credits through Social Security to qualify.

Older or disabled adults who received Supplemental Security Income (SSI) from the SSA are automatically eligible for Medicaid but must make an application for assistance with DCF. Each state establishes its own process for handling Medicaid applications.

Those who do not receive SSI payments will likely have to meet a spenddown and must not have more than \$2,000 in assets for a single individual or \$3,000 for a married couple.

How does a person apply?

A beneficiary can apply for assistance through KanCare online or with a paper application. Information and applications are available at <http://www.kancare.ks.gov/apply.htm>. The KanCare Clearinghouse processes KanCare applications.

- ✓ If you have questions you can contact the KanCare Clearinghouse toll free at 1-800-792-4884.
- ✓ Write your name and/or social security number on each document you want to send. Include the confirmation number from your application if you have it.
 - Mail or fax copies of documents to the KanCare Clearinghouse at:
KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601,
Fax application to 1-844-264-6285.

Dual-Eligible (DE)

Dual-eligibles are persons who qualify, in some way, for both Medicare and Medicaid coverage.

Medically Needy or Medicaid with a Spenddown – Seniors and People with Disabilities

Persons with higher income may qualify for Medically Needy coverage. Single persons must have less than \$2000 in assets. Married couples must have less than \$3000 in assets.

A spenddown works like an insurance deductible. Persons must incur medical costs equal to the spenddown before Medicaid will pay. When a person meets his or her spenddown, Medicaid will pay. The spenddown is usually figured for a six-month base period. The person's income is used to find their spenddown amount. The protected income limit for the elderly and people with disabilities is \$495.00 for one or two people and \$500 for three people. For adults, only the income of the person needing coverage and their spouse is used. Almost every person has a different spenddown amount.

What Is a Spenddown?

Medical expenses paid by the client are used to "spend down" to the Medicaid income limit. Medicaid will then pay for expenses incurred during the period that the client did not use to meet the spenddown. The spenddown is the individual's responsibility and is calculated based on a six-month period.

Medical expenses that can be used for a spenddown include:

- Health Insurance and Medicare premiums
- Prescription drugs
- Dental care expenses including dentures
- Physicians services
- Hospital costs
- Nursing home expenses
- Home health care expenses
- Some over-the-counter drugs ONLY if prescribed by a doctor
- Medical transportation costs
- Eye doctors and eyeglasses
- Some medical equipment including hearing aids

To receive a medical card the applicant must provide bills or proof of their medical expenses (that equal or exceed their spenddown amount) to their case manager.

Income

Income is counted in the month it is received. Income remaining at the beginning of the next month becomes a resource. Some income is not counted and only KanCare economic assistance specialists can determine if a person meets income limits.

Countable Income

All income is counted unless specifically excluded. This includes the following:

- Wages
- Social Security
- Veterans retirement income and disability pensions
- Private pensions
- Income from investments
- Payments or donations by a third party for basic needs (food, shelter, and clothing)

Where Can I Get Advice On This Subject?

For advice regarding Spousal impoverishment, contact: The *Kansas Elder Law Hotline* (1-888-353-5337) or the local Area Agency on Aging or a family attorney.

Transfer of Resources

Transfers of resources may be completed to remove them from being counted toward Medicaid eligibility limits. When a resource is transferred, the original owner gives up ownership, control, and benefit of the resource.

Transfer completed within certain look-back periods from the date of Medicaid application will be reviewed to see if the resident received compensation equal to fair market value. Any uncompensated value will be used in calculating a penalty period during which Medicaid will not pay for nursing facility or HCBS costs.

It is important for people to know the changes in the law as they are planning. For those who are considering plans which may include transfer activity of any type, it is necessary to have professional and competent legal and financial advice.

The Law (Effective August 10, 1993)

In the Omnibus Budget Reconciliation Act (OBRA) of 1993, Congress changed the law regarding transfers. Transfers done on or after that date are subject to the following guidelines:

Look-Back Period - for transfers to determine eligibility for Medicaid. All transfers are subject to a 60-month look-back time limit. (5 years)

Penalty Period - There is NO maximum on the number of months for a penalty period based on ineligible transfers. The penalty period is calculated by dividing the uncompensated value of an ineligible transfer by \$3,000.

NOTE: Call an Attorney or the Elder Law Hotline 1-888-353-5337

Estate Recovery

The State of Kansas is authorized to recover medical assistance costs from the estate of a deceased Medicaid recipient. Estate recovery is limited to recipients who were receiving long-term institutional or HCBS care at the time of their death, or if they were not in long-term care at the time of death, were 55 years of age or older at the time of death.

Estate recovery is further limited to deceased recipients who have no surviving spouse, no surviving children under the age of 21, and no surviving children regardless of age, who are permanently and totally disabled or blind. If there is a surviving spouse, then the recovery is deferred until the death of the surviving spouse. If there is a surviving child who meets one of the criteria mentioned above, the recovery is waived.

KDHE contracts with Health Management Systems (HMS), Kansas Estate Recovery Contractor, ksestaterecovery@hms.com, phone: 800-817-8617. KDHE Estate Recovery can be contacted by phone at (785) 296-6707.

More specific information can be found at <http://www.kancare.ks.gov/docs/default-source/Consumers/benefits-and-services/fact-sheets/estate-recovery-fact-sheet-2018-01.pdf>

NOTE: Call an Attorney or the Elder Law Hotline 1-888-353-5337

Other Assistance Programs

Kansas Relay Center

The Kansas Relay Center allows specially trained operators to relay conversations between persons with speech and/or hearing impairments and those who can hear and speak. The service is offered seven days a week, 24-hours a day. CALL 1-800-766-3777 (Voice/TTY) or 1-866-305-1344 (Speech to Speech) or 1-866-305-1343 (Spanish) to use the Relay Center. See their website at <http://www.da.ks.gov/phonebook/specialservices.htm>.

Kansas TAP - Kansas Telecommunication Access Program

The Kansas Telecommunications Access Program (TAP) is an equipment distribution program. The purpose of the program is to provide specialized telephones and other telecommunications devices to Kansans with disabilities who can't use traditional home telephones. Based on a state law, the program receives funds through the Kansas Universal Service Fund (KUSF) and is regulated by the Kansas Corporation Commission (KCC).

Assistive Technology for Kansans (ATK) began to manage Kansas TAP in May 2014. The management office is located in Parsons and each of the regional AT Access Sites and the affiliate office assist with applications and provide demonstrations. Contact: Assistive Technology for Kansans – (800) 526-3648 or E-mail: tkapps@ku.edu or write to 2601 Gabriel, Parsons, KS 67357. See their website at <http://atk.ku.edu/ks-tap>.

Free or Low-Cost Dental Care

The Kansas Foundation of Dentistry for the Handicapped (KFDH) has sponsored the Donated Dental Service Program (DDS) since 1985. It was designed to help disabled and elderly persons who are indigent by matching them with volunteer dentists. Dentists throughout Kansas have volunteered to participate. Applicants must be permanently disabled, chronically ill, or elderly; unable to afford dental care or not be able to get care through other programs; and need extensive treatment, beyond cleaning and a check-up.

Applications are reviewed and placed on a waiting list. Because of overwhelming need, each patient only receives DDS service one time.

To receive an application or for information contact DDS Coordinator, 5200 SW Huntoon, Suite A, Topeka, KS 66604-2398, 888-870-2066, or 785-273-1900

Free Eye Exams

Eye Care America helps to ensure that all eligible seniors have access to medical eye care and promotes annual, dilated eye exams. The organization raises awareness about age-related eye disease, including cataracts, provides **free** eye care educational materials, and facilitates access to eye care.

People eligible for a referral through the program receive a comprehensive, medical eye exam and up to one year of care—at no out-of-pocket cost—for any disease diagnosed during the initial exam. Volunteer ophthalmologists accept Medicare and/or other insurance reimbursement as payment in full.

The program is designed for people who:

- Are US citizens or legal residents
- Are age 65 and older
- Have not seen an ophthalmologist in three or more years
- Do not belong to an HMO or the VA

Chapter 12

SHICK COUNSELOR PROTOCOLS

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COUNSELING TOOLS

SHICK is a free, unbiased and confidential program that uses trained, community volunteers to answer people's questions about Medicare and other insurance issues.

Our counselors do not work for any insurance company. Their goal is to educate and assist the public in making informed decisions about their health care options.

The ideal SHICK counselor has:

- the ability to work with others
- a caring, confident attitude
- the ability to understand health care information and options
- a willingness to stay up-to-date with changing regulations
- familiarity with computers and the internet
- good communication skills
- strong organizational skills
- time to commit to multiple ongoing projects

As a counselor, you will be called upon to provide accurate, unbiased health insurance information in a supportive, easy to understand manner that will enable the client to make well-informed decisions. The Counselor's job responsibilities emphasize the role that effective interpersonal and communication skills play in providing services. The training that Counselors receive provides opportunities for developing and applying communication skills and techniques to assure that clients feel comfortable in seeking assistance and that clients understand what their options are regarding Medicare and other insurances.

Training

SHICK volunteers receive training on Medicare, Medicare Prescription Drug Insurance, Medicare Supplement Insurance, Long-Term Care Insurance and other health insurance subjects that concern Kansans. Training is offered in local communities, and there are also online options.

Support

Volunteers are supported by staff at the state and local level. Regional SHICK Coordinators provide assistance, office space and equipment, supplies, and training support to volunteers in their areas.

Satisfaction

Health insurance options can be confusing. SHICK volunteers help Medicare beneficiaries, caregivers, and others to understand their choices, access the benefits available to them, and find programs to help pay for medications and other services.

SHICK Counselor Responsibilities and Obligations

SHICK counselors are expected to attend SHICK Update training each year, after completing their initial training. They are required to read and sign a Memorandum of Understanding each year agreeing to follow all program guidelines and regulations. They are also expected to track client contacts and public and media events if applicable. SHICK uses the SHIP National Performance Reporting (NPR) system to report all contact data. This system is available through <https://shipnpr.acl.gov>, a secure website used to enter Client Contact forms (CC) and Public and Media (PAM) activity. Beginning in 2018, the National SHIP data reporting system will be changing to a new system named "STARS."

What is a Client Contact?

A client contact includes all contacts between a counselor or staff and a client, which may include Medicare or Medicaid beneficiaries, seniors, and their family members or others working on behalf of a client. Client contacts may be conducted over the telephone, in person (on site), in person (at home), or via postal mail, e-mail, or fax.

When should I fill out a Client Contact form?

A Client Contact or CC form must be completed or updated for each contact between a counselor/staff and a beneficiary or his/her representative. The Client Contact form is used by registered State Health Insurance Assistance Program (SHIP) counselors only. These individuals must have received counselor training and signed a Counselor Agreement or Memorandum of Understanding (MOU) with their local SHIP agency, SHICK. SHICK counselors may include volunteers, agency staff, toll-free Help Desk counselors, and local coordinators/sponsors.

Client Contact forms are considered confidential and must be treated by counselors as confidential information. The counselor must assure the client that all personal information collected is confidential.

The CC form and instructions for using the national SHIP data entry website to enter client contacts are on the SHICK website, <http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/shick-shipnpr-data-reporting>.

What is a Public and Media activity?

A PAM form must be completed for each PAM event carried out by SHICK. A Public and Media (PAM) activity can include an in-person interactive presentation to the public conducted by SHICK; a booth/exhibit at a fair, conference, or other public event; and a radio, TV, or Web site event. Detailed definitions of each of these PAM events are included in the SHIPNPR PAM user manual.

When should I fill out a PAM form?

The PAM form and instructions for using the national SHIP data entry website to enter public and media events are on the SHICK website, <http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/shick-shipnpr-data-reporting>.

Communication Techniques

During a counseling session please keep in mind these communication techniques to facilitate understanding between you and your clients:

- Provide assurances of confidentiality.
- Treat your client with respect from your initial contact through all phases of the service you provide.
- Listen patiently as the client describes his/her situation.
- Ask clarifying questions to focus the discussion.
- Ask “open-ended” questions to clarify information and check that you understand key points.
- Maintain a cordial but professional tone throughout your interactions with the client.
- Observe signs of anxiety or misunderstanding and provide appropriate assurances to ease your client’s discomfort.

- Summarize often during conversations with your client to confirm that you understand the client's situation.
- Take care to define terms and explain concepts in ways that the client will understand.
- Provide precise explanations paced appropriately to avoid misunderstanding.
- Encourage the client to participate in pursuing ways to resolve his/her health insurance-related problems.
- Remain flexible about your ideas for resolving problems and be open to your client's ideas. Obtain the client's approval before taking action on his/her behalf.
- Provide information the client can take with them for a reminder of what was talked about.
- If follow-up is needed be specific about when you will be contacting the client or what the next step in the process may be.

Counseling Guidelines

Protecting Beneficiary Privacy

As a SHICK counselor, you will have access to beneficiaries' health information as well as personal identifying information like Medicare numbers and Social Security Numbers. You must handle this information carefully and keep it confidential to protect beneficiaries from fraud, identity theft, health-based discrimination, and other potential problems.

- Only collect the information you need to provide the help the beneficiary has asked for (for example, you don't need a list of medications to help someone enroll in a Medigap plan).
- Only share beneficiary information with people or agencies who are directly involved in providing the help the beneficiary has asked for (like a Part D plan, for example).
- Don't keep beneficiary information on a laptop or in a file that you take out of the office with you.
- Don't leave beneficiary information out on a desk or up on a computer screen where it can be seen by others.
- Conduct counseling sessions in private where personal information shared by the beneficiary won't be overheard by others.
- If you believe beneficiary information has been lost, stolen or misused, contact your SHICK Coordinator immediately.
- If you believe a beneficiary has been the victim of fraud or identity theft, contact your Kansas SMP Coordinator and/or SHICK Coordinator immediately.

Conflict of Interest

SHICK counselors are trusted resources for Medicare beneficiaries. To maintain that trust, counselors cannot be allowed to profit in any way from their contacts with beneficiaries. SHICK has adopted several rules to ensure that no volunteer has a conflict of interest that would prevent him or her from providing unbiased counseling.

- Anyone who is currently associated with the insurance industry is prohibited from being a SHICK volunteer counselor.
- Anyone who could use their position as a SHICK counselor to solicit business from beneficiaries is prohibited from being a SHICK volunteer.

Chapter 14

APPENDIX

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2018 Overview of Medicare A & B

Key: Shaded areas – Medicare Pays

White areas – You Pay

A		B	
Premium:	<i>40 work quarters = zero</i> <i>less than 30 quarters = \$422</i> <i>30 - 39 quarters = \$232</i>	Premium:	\$130 to \$134 unless individual income over \$85,000 or couple \$170,000.
Each benefit period*		\$183 Deductible (per calendar year, January 1 to December 31)	
In-patient Hospital		80%	20%
First 60 days	\$1340 Deductible	Physician's Charges (in or out of the hospital) Durable Medical Equipment & Supplies Ambulance Outpatient Hospital Blood Lab Services	C O I N S U R A N C E
Days 61-90	\$335 per day co-payment		
Lifetime Reserve Days			
91-150	\$670 per day co-payment		
Skilled Nursing Facility			
First 20 days	100% (No co-pay)	The first 3 pints	
Days 21-100	\$167.50 per day co-pay		
100% Services		Preventive Services	
Home Health		PAID 100%: Welcome to Medicare Physical Exam, Screening Mammograms, Annual Pap Tests, Diabetes Screening, Bone Mass Measurement, Flu Shots, some Colorectal Cancer Screening, Screening & Counseling for Obesity, Medical Nutrition Therapy, Tobacco Use Cessation, Yearly Wellness Visit	
Hospice		WITH CO-PAY OR DEDUCTIBLE: Abdominal Aortic Aneurysm Screening, Diabetes Supplies & Self-Management, Prostate Cancer Screening, Glaucoma Screening, CCS - Barium enema, HIV Screening	
	\$5 prescription drug co-pay	Excess Charges (15% over Medicare Allowed Charge)	
	5% co-insurance inpatient respite care		
* Benefit period ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.			

Annual Medicare Premium and Cost-Sharing Amounts 2018

Part A – Hospital Insurance

Part A Standard Premium – No charge for most people (at least 40 work credits)
 \$422.00 per month for people with less than 30 work credits
 \$232.00 per month for people with 30 to 39 work credits

Part A – Hospital Insurance – Covered Services (Per Benefit Period)

Part A Deductible for Each Benefit Period	\$1,340.00
Hospital Inpatient	\$0 for days 1 - 60 \$335.00 a day for days 61 to 90 \$670.00 a day for days 91 – 150 (lifetime reserve days) All costs for days after 150
Skilled Nursing Facility	\$0 for days 1 – 20 \$167.50 a day for days 21 – 100 All costs for all days after 100
Home Health Care	\$0 for home health care services 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	\$0 for hospice care You may need to pay a copayment of no more than \$5 for each prescription drug and other similar products for pain relief and symptom control while you're at home. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D. You may need to pay 5% of the Medicare-approved amount for inpatient respite care. Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Blood	Blood Transfusion

Part A Late Enrollment Surcharges/Penalties:

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

Part B -Medical Insurance

Part B deductible - \$183 per year

Part B coinsurance -After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment.

Part B Standard Premium - \$134 per month (or higher depending on your income)

However, some people who get Social Security benefits will pay a lower Part B premium amount (average \$130.00 for most people), if their Part B premium was deducted from their December 2017 and January 2018 Social Security or Railroad Retirement benefits (they are held harmless). This is because the cost-of-living increase of 2% for 2018 Social Security benefits was not enough to prevent a lower SSA benefit for the full \$134 premium. You'll pay a higher premium amount in 2018 if:

1. You enroll in Part B for the first time in 2018.
2. You don't get Social Security benefits.
3. You're directly billed for your Part B premiums.
4. You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of \$134.)
5. Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount.

If you're in 1 of these 5 groups, your 2018 Part B monthly premium rates are listed below.

If Your Yearly Income in 2016 (for what you pay in 2018) was			You pay (in 2018)
File Individual Tax Return	File Joint Tax Return	File married and separate tax return	
\$85,000 or below	\$170,000 or below	\$85,000 or less	\$134.00
\$85,001–\$107,000	\$170,001–\$214,000	Not applicable	\$187.50
\$107,001–\$133,500	\$214,001–\$267,000	Not applicable	\$267.90
\$133,501–\$160,000	\$267,001–\$320,000	Not applicable	\$348.30
above \$160,000	above \$320,000	Above \$85,000	\$428.60

*If beneficiary pays a late-enrollment penalty, this amount is higher.

Part B Late Enrollment Surcharges/Penalties:

If you don't sign up for Part B when you're first eligible, or if you drop Part B and then get it later, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could've had Part B, but didn't sign up for it.

Part D – Medicare Prescription Drug Coverage

Part D Base Beneficiary Premium -\$35.02 (Used to determine any late enrollment penalty amount).

Listed below are the 2018 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

If Your Yearly Income in 2016 (for what you pay in 2018) was			You pay (in 2018) Income-related monthly adjustment amount + your plan premium (YPP)
File individual tax return	File joint tax return	File married and separate tax return	
\$85,000 or below	\$170,000 or below	\$85,000 or less	\$0.00 + YPP
\$85,001–\$107,000	\$170,001–\$214,000	Not applicable	\$13.30 + YPP
\$107,001–\$133,500	\$214,001–\$267,000	Not applicable	\$34.20 + YPP
\$133,501–\$160,000	\$267,001–\$320,000	Not applicable	\$55.20 + YPP
above \$160,000	above \$320,000	Above \$85,000	\$76.20 + YPP

Part D deductibles, copayments, & coinsurance

The amount you pay for Part D deductibles, copayments, and/or coinsurance varies by plan. Look for specific Medicare drug plan costs, and then call the plans you're interested in to get more details.

Defined Standard Plan (Basic Benefit) in 2018

What you pay	100%	25%	35% brand names 44% generics	5%
What Medicare pays	0%	75%	65% brand names 54% generics	95%
Costs	\$0 - \$405	\$405 - \$3750	\$3751-\$7508.75	Drug costs > \$7508.75 OOP Max \$5000
Coverage Level	Deductible 1	Initial Coverage Level 2	Coverage Gap 3	Catastrophic Coverage 4

2018 Monthly Poverty Guidelines

2018 poverty guidelines for the 48 contiguous states and the District of Columbia

Persons in family/ household	100%	120%	135%	140%	145%	150%
1	\$1,012	\$1,214	\$1,366	\$1,416	\$1,467	\$1,518
2	\$1,372	\$1,646	\$1,852	\$1,920	\$1,989	\$2,058
3	\$1,732	\$2,078	\$2,338	\$2,424	\$2,511	\$2,598
4	\$2,092	\$2,510	\$2,824	\$2,928	\$3,033	\$3,138
5	\$2,452	\$2,942	\$3,310	\$3,432	\$3,555	\$3,678
6	\$2,812	\$3,374	\$3,796	\$3,936	\$4,077	\$4,218
7	\$3,172	\$3,806	\$4,282	\$4,440	\$4,599	\$4,758
8	\$3,532	\$4,238	\$4,768	\$4,944	\$5,121	\$5,298

Federal poverty level guidelines at: <https://aspe.hhs.gov/poverty-guidelines>.

2018 Resource Standards for Individuals/Couples

	With Burial Exclusion	Without Burial Exclusion
Lower Resources Level	\$9,060/\$14,340	\$7,560/\$11,340
Higher Resources Level	\$14,100/\$28,150	\$12,600/\$25,150

Medicare Savings Programs (MSPs): Eligibility and Coverage (2018)

Type of MSP	Financial Eligibility	Benefits Covered by MSP
Qualified Medicare Beneficiary (QMB)	Monthly Income*: At or below 100% FPL Resources: Lower resource level	Part A hospital deductible (\$1,340/per benefit period) Part A hospital copays: days 61-90 (\$335 daily), days 91-150 (\$670 daily) Part A SNF copays: days 21-100 (\$167.50 daily) Part A premium (\$422 for most voluntary enrollees) Part B annual deductible (\$183) Part B monthly premium (\$134) Part B coinsurance (amount varies)
Specified Low-Income Medicare Beneficiary (SLMB)	Monthly Income*: Between 100-120% FPL Resources: Lower resource level	Part B monthly premium (\$134)
Qualifying Individual (QI) or Expanded LMB (ELMB)	Monthly Income*: 121-135% FPL Resources: Lower resource level	Part B monthly premium (\$134)
Qualified Disabled Working Individual (QDWI)	Monthly Income**: \$4,045 if single \$5,425 if married Resources: \$4,000 if single, \$6,000 if married	Medicare Part A premium (for people with Medicare who are under age 65, disabled, and no longer qualify for free Medicare Part A or Medicaid because they returned to work and their income exceeds the limit)

Medicare Drug Plan Costs if You Automatically Qualify for Extra Help

If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until \$4,900)	Your cost per prescription (after \$4,900)
Full Medicaid coverage & for each full month you live in an institution, like a nursing home	\$0	\$0	\$0	\$0
Full Medicaid coverage & yearly income below 100% FPL	\$0	\$0	\$1.25 for generic & certain preferred drugs; \$3.70 for brand-name drugs	\$0
Full Medicaid coverage & yearly income above 100 % FPL	\$0	\$0	no more than \$3.35 for generic & certain preferred drugs; no more than \$8.35 for brand-name drugs	\$0
Medicare Savings Program – all levels	\$0	\$0		\$0
Get Supplemental Security Income (SSI) but not Medicaid	\$0	\$0		\$0

Medicare Drug Plan Costs if You Apply and Qualify for Extra Help

If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until 4,900)	Your cost per prescription (after \$4,900)
a yearly income at or below 135% FPL Lower resource level	\$0	\$0	\$3.35 for generic & certain preferred drugs; \$8.35 for brand-name drugs	\$0
a yearly income below 135% FPL Higher resource level	\$0	\$82	up to 15% of the cost of each prescription	no more than \$3.35 for generic & certain preferred drugs; no more than \$8.35 for brand-name drugs
a yearly income between 135% and 140% FPL higher resource level	25%			
a yearly income between 140% and 145% FPL higher resource level	50%			
a yearly income between 145% and 150% FPL higher resource level	75%			

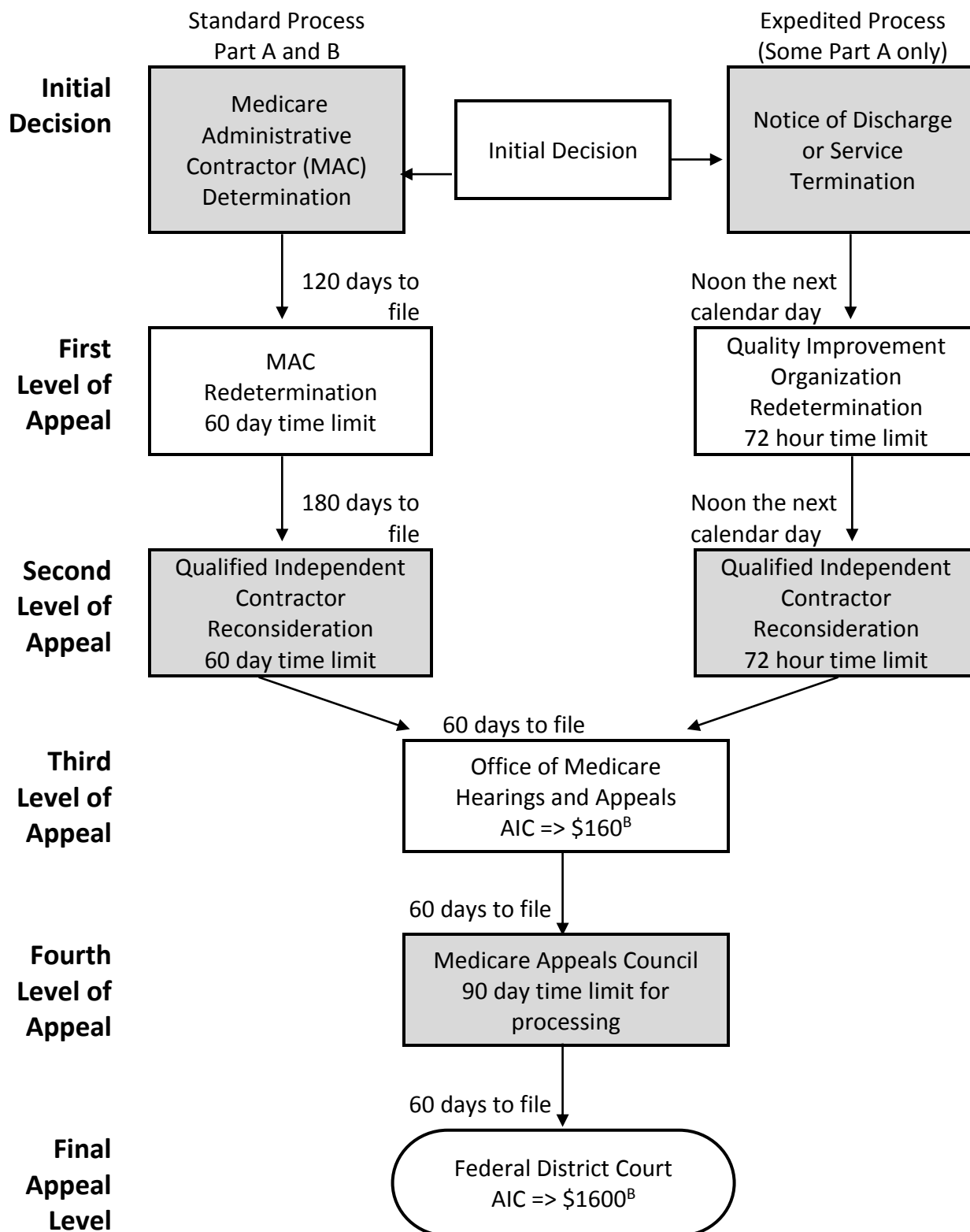
Notes:

*Income limit does not include \$20 “unearned income disregard.” States may disregard other income as well.

**This includes additional earned income exclusions

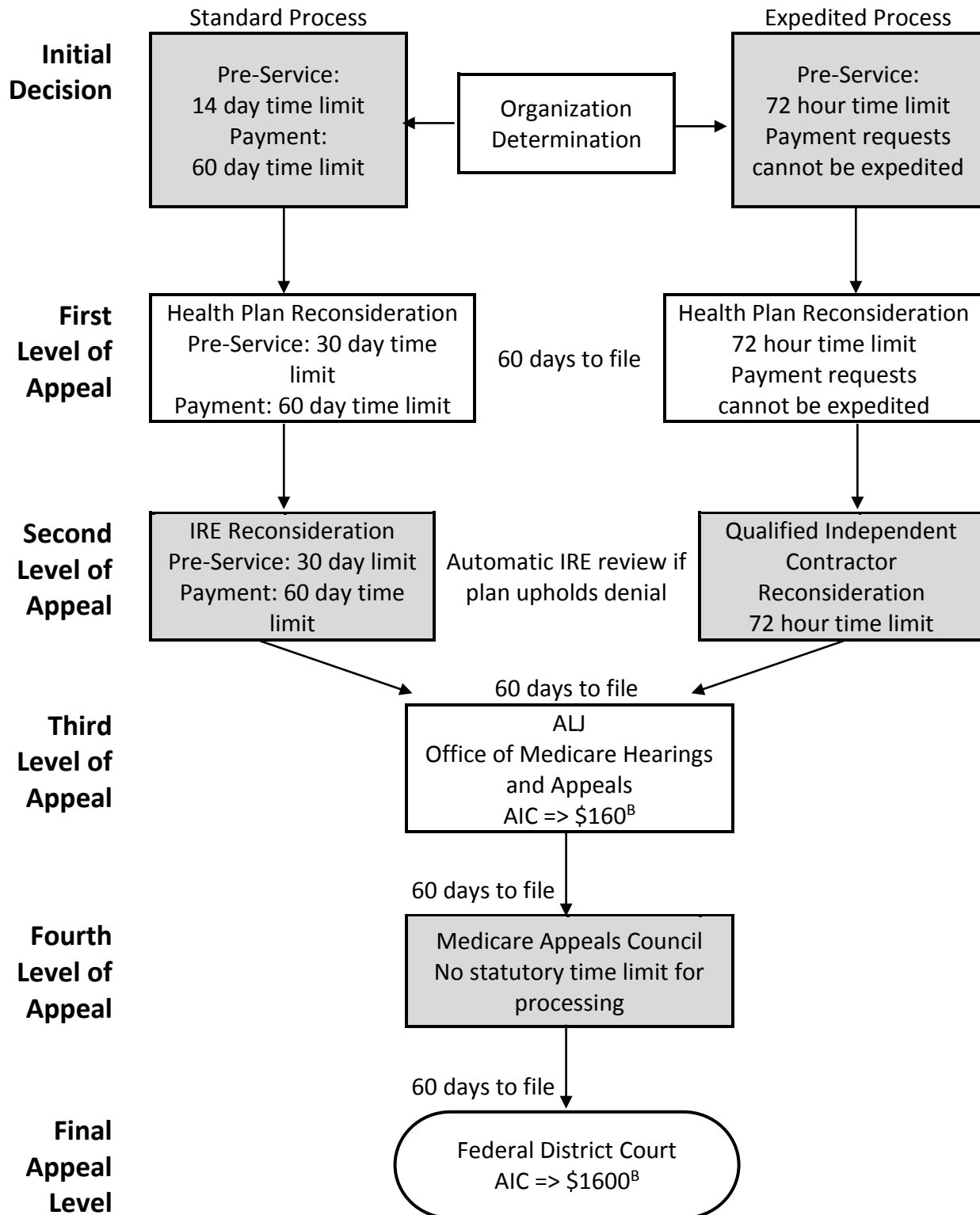
Note: There are plans with no monthly premium. There are other plans where the beneficiary will have to pay part of the premium even when qualifying for full extra help. The beneficiary should tell the plan that he/she qualifies for extra help and ask how much the monthly premium will be.

Parts A & B (Fee-for-Service) Flowchart



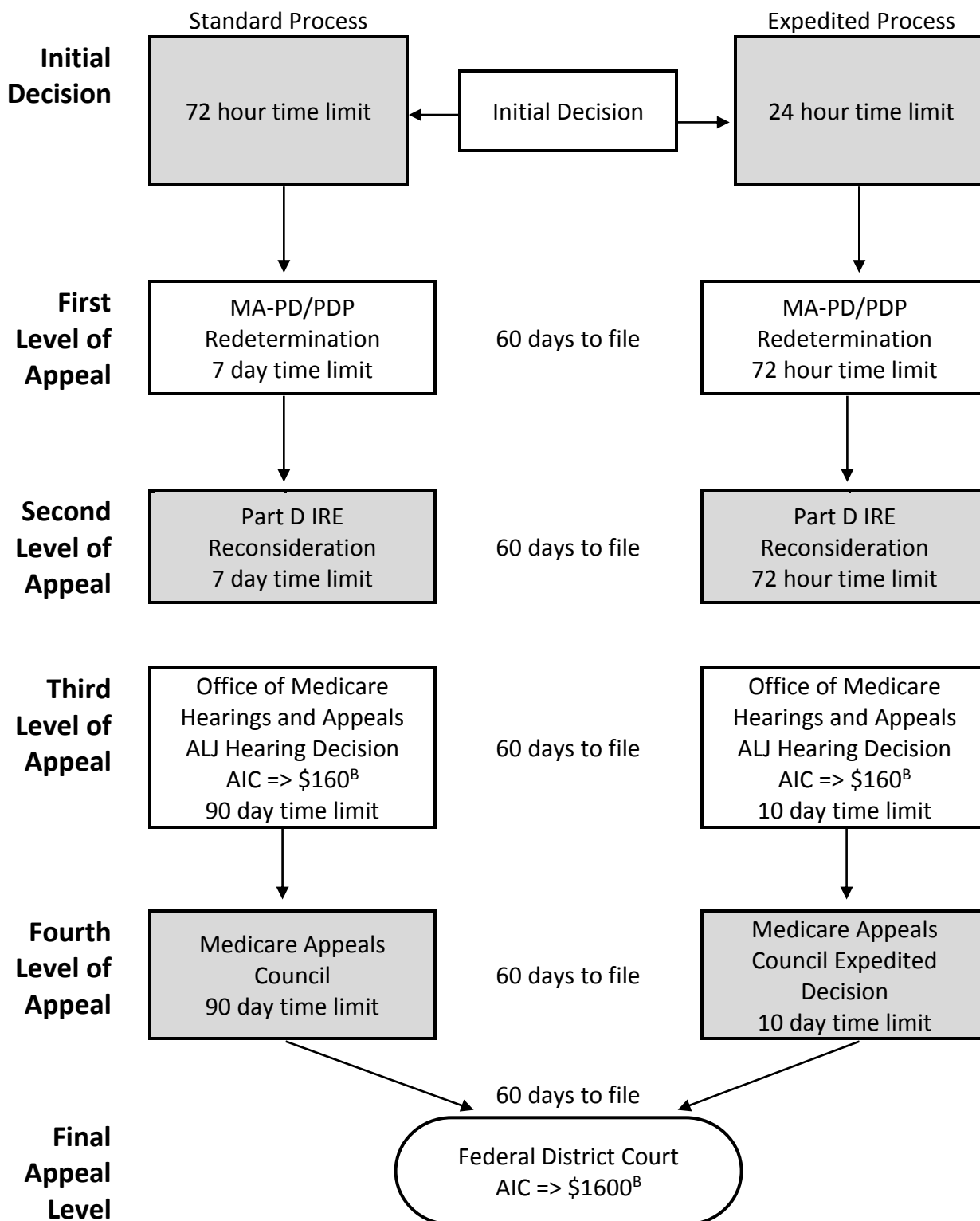
B = 2018 Amount

Part C (MA) Appeals Flowchart



B = 2018 Amount

Part D (Drug) Appeals Flowchart



B = 2018 Amount

Standard Medicare Supplement Policies at a Glance

	A	B	C	D	F*	G	K	L	M	N
Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess Charges					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
							Out-of-Pocket Limit**			
							\$5,240	\$2,620		

*Plan F also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of \$2,240 in 2018 before your Medicare supplement plan pays anything.

**After you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$183 in 2018), the Medicare supplement plan pays 100% of covered services for the rest of the calendar year. Out-Of-Pocket Annual Limit will increase each year for inflation. The Out-Of-Pocket Annual Limit DOES NOT include “excess charges.” The beneficiary is responsible for these charges.

***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don’t result in an inpatient admission.

Websites of Interest

SHICK Website – <http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick>

This website is the SHICK webpage on the Department on Aging website

SHICK Listserv Information Page – <https://www.accesskansas.org/mailman/listinfo/shick>

Use this page to access subscription information for the SHICK listserv and the SHICK listserv Archives. A password is required to access the archives.

SHIPNPR SHIP Talk - <https://SHIPNPR.shiptalk.org>

Use this page to enter Client Contact reports and Public and Media Event reports. You can also view reports and access contact information for other state SHIPs.

Kansas Department for Children and Families – <http://www.dcf.ks.gov>

Kansas Insurance Department – <http://www.ksinsurance.org/>

Kansas Department for Aging and Disability Services - <http://www.kdads.ks.gov/>

Quality Improvement Organization (QIO) -

Beneficiary and Family Centered Care (BFCC)-QIOs – KEPRO - <https://www.keprogio.com/>

BFCC-QIOs improve healthcare services and protect beneficiaries through expeditious statutory review functions, including complaints and quality of care reviews for people with Medicare.

Quality Innovation Network (QIN)-QIO – Great Plains Quality Innovation Network -

<http://greatplainsqin.org/>

QIN-QIOs improve healthcare services through education, outreach, sharing practices that have worked in other areas, using data to measure improvement, working with patients and families and convening community partners for communication and collaboration.

Wisconsin Physicians Service Insurance Corporation (WPS) - <http://www.wpsmedicare.com/>

This organization is currently processing all Kansas Part A claims and all Kansas Part B claims except for Durable Medical Equipment.

Noridian Administrative Services - <https://www.noridianmedicare.com/dme/>

This organization is currently processing all Kansas Part B claims for Durable Medicare Equipment.

Medicare – <http://www.medicare.gov>

Centers for Medicare and Medicaid Services – <http://www.cms.gov/>

Social Security Administration – <http://www.ssa.gov/>

Official Medicare Website: Centers for Medicare & Medicaid Services

<http://www.cms.gov/home/medicare.asp>

Medicare Policy Manuals: CMS

<http://www.cms.gov/manuals>

BenefitsCheckUp and BenefitsCheckUp Rx

<http://www.benefitscheckup.org>

Center for Medicare Advocacy

<http://www.medicareadvocacy.org>

Center for Social Gerontology

<http://www.tcsg.org>

Kaiser Family Foundation Medicare Policy Project

<http://www.kff.org/medicare>

Medicare Rights Center

<http://www.medicarerights.org>

NOTE: Secure websites require the “https://” preface to enter the site. This preface is included for all secure websites on this page.

Health Insurance Claim Number (HICN) Prefixes and Suffixes

What is the Health Insurance Claim Number?

The HICN is the number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary.

How is the HICN formatted?

If the HICN starts with a number, the first nine positions must be numeric. The final position is one of the following:

A: Signifies a retired worker over 65 years old or a disabled worker.

B1 Husband of a retired or disabled worker

B2 Young Wife with a child in her care

B3 Second wife

B4 Second husband

B5 Second wife with a child in her care

B6 Ex-wife with a child in her care

B7 Third wife with a child in her care

B8 Third wife

B9 Second ex-wife

BA Fourth wife

BD Fifth wife

BG Third husband

BH Fourth husband

BJ Fifth husband

BK Fourth wife with a child in her care

BL Fifth wife with a child in her care

BN Third ex-wife

BP Fourth ex-wife

BQ Fifth ex-wife

BR Ex-husband

BT Second ex-husband

BW Second husband with a child in his care

BY Husband with a child in his care

C: Signifies a child or grandchild, including a disabled child or student. This letter may be followed by any number 1-9 or letter A-Z. The suffixes for these beneficiaries are assigned by age (i.e. C1 Youngest C2 next youngest, etc.)

D: Signifies a widower. This letter may be followed by numbers 1-9 or letters

A, C, D, G, H, J, N, P, T, or V-Z.

D1 Widower

D2 Second widow

D3 Second widower

D4 Widow, remarried after age 60

D5 Widower, remarried after age 60

D6 Surviving ex-wife

D7 Surviving second ex-wife

D8 Third widow

D9 Second remarried widow

DA Third Remarried widow

DC Surviving ex-husband

DD Fourth widow

DG Fifth widow

DH Third widower

DJ Fourth widower

DK Fifth widower

DL Fourth remarried widow

DM Surviving second ex-husband

DN Fifth remarried widow

DP Second remarried widower

DQ Third remarried widower

DR Fourth remarried widower

DS Surviving third ex-husband

DT Fifth remarried widower

DV Surviving third ex-wife

DW Surviving fourth ex-wife

DX Surviving fourth ex-husband

DY Surviving fifth ex-wife

DZ Surviving fifth ex-husband

The HICN represents a Railroad Retirement Board (RRB) beneficiary when the following characters are present on the health insurance card as a prefix in front of the HIC number instead of a suffix after it. The number itself has either six digits or nine digits. The following are the most common prefixes for Railroad Retirement beneficiaries.

- A** Retired railroad worker (annuitant)
- H** Retired worker on a pension
- JA** Survivor “joint annuitant,” an employee who is receiving a reduced annuity in order to guarantee payment to his widow
- MA** Spouse of an annuitant
- MH** Spouse of a pensioner
- PA** Parent of a deceased annuitant
- PD** Parent of a deceased employee
- PH** Parent of a deceased pensioner
- WA** Widow or widower of an annuitant who is 60 or over.
- WCA** Widow with a child in her care, or child alone (of annuitant)
- WCD** Widow with a child in her care, or child alone (of an employee)
- WCH** Widow with a child in her care, or child alone (of a pensioner)
- WD** Widow or widower of an employee who is 60 or over.
- WH** Widow or widower of a pensioner

In April 2018, CMS began issuing new Medicare Cards with new Medicare numbers. These new numbers are called the Medicare Beneficiary Identifier or MBI. The mailing of the new cards will be completed by April 1, 2019. This initiative is required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). To protect seniors from identity theft, the law required the Department of Health and Human Services (HHS) to issue new Medicare cards that did not display, code, or embed SSNs by April 2019. The new Medicare Beneficiary Identifier will not include the suffixes the HICN used.

Understanding the Medicare Beneficiary Identifier (MBI) Format

How many characters will the MBI have?

The MBI has 11 characters, like the Health Insurance Claim Number (HICN), which can have up to 11.

Will the MBI's characters have any meaning?

Each MBI is randomly generated. This makes MBIs different than HICNs, which are based on the Social Security Numbers (SSNs) of people with Medicare. The MBI's characters are "non-intelligent" so they don't have any hidden or special meaning.

What kinds of characters will be used in the MBI?

MBIs are numbers and upper-case letters. We'll use numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read.

How will the MBI look on the new card?

The MBI will contain letters and numbers. Here's an example: 1EG4-TE5-MK73

- The MBI's 2nd, 5th, 8th, and 9th characters will always be a letter.
- Characters 1, 4, 7, 10, and 11 will always be a number.
- The 3rd and 6th characters will be a letter or a number.
- The dashes aren't used as part of the MBI. They won't be entered into computer systems or used in file formats.

MBI Format											
Pos.	1	2	3	4	5	6	7	8	9	10	11
Type	C	A	AN	N	A	AN	N	A	A	N	N

Where will the MBI's characters go?

C – Numeric 1 thru 9 **N** – Numeric 0 thru 9 **AN** – Either A or N **A** – Alphabetic Character (A...Z); Excluding (S, L, O, I, B, Z)

Position 1 – numeric values 1 thru 9

Position 2 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 3 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)

Position 4 – numeric values 0 thru 9

Position 5 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 6 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)

Position 7 – numeric values 0 thru 9

Position 8 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 9 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 10 – numeric values 0 thru 9

Position 11 – numeric values 0 thru 9

How will the MBI fit on forms?

MBIs will fit on forms the same way HICNs do. You don't need spaces for dashes.

Who will get a new MBI?

Each person with Medicare will get their own randomly-generated MBI. Spouses or dependents who may have had similar HICNs will each get their own different MBI.

Common Acronyms for People with Medicare

A	
AAA	Area Agency on Aging
AAA	Abdominal Aortic Aneurysms
AARP	American Association of Retired Persons
A/B MAC	A/B Medicare Administrative Contractor
ABD	Aged, Blind & Disabled
ABN	Advanced Beneficiary Notice
ACA	Affordable Care Act
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADC	Adult Day Care
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center
AEP	Annual coordinated election period (10/15 – 12/7 each year)
AI/AN	American Indian/Alaska Native
AIC	Amount in controversy
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
ALS	Amyotrophic Lateral Sclerosis
ANOC	Plan Annual Notice of Change
AO	Accreditation Organization
AOA	Administration on Aging
APTC	Advanced Premium Tax Credits
ARRA	American Recovery and Reinvestment Act 2009
AVF	Arteriovenous Fistulas
B	
BAE	Best Available Evidence
BBA	Balanced Budget Act (of 1997)
BBRA	Balanced Budget Refinement Act (of 1999)
BC/BS	Blue Cross/Blue Shield
BCRC	Benefits Coordination & Recovery Center
BFCC	Beneficiary and Family Centered Care
BFCC-QIO	Beneficiary and Family-Centered Care Quality Improvement Organization
BHP	Basic Health Program
BMI	Body Mass Index
BP	Benefit Period
BPH	Benign Prostatic Hyperplasia
C	
CAH	Critical Access Hospital
CAL	Compassionate Allowance
CBO	Community-Based Organizations
CBO	Congressional Budget Office
CCN	Claim Control Number

CCRC	Continuing Care Retirement Community
CFC	Conditions for Coverage
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHIP	Children's Health Insurance Program
CKD	Chronic Kidney Disease
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of benefit(s)
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act (of 1985)
CORF	Comprehensive Outpatient Rehab Facility
CP	Claims Processing
CPAP	Continuous positive airway pressure
CPI	Center for Program Integrity
CSR	Customer Service Representative
CSR	Cost Sharing Reductions
CVD	Cardiovascular disease
CWF	Current Working File
CY	Calendar Year

D

DCF	Kansas Department for Children and Families, formerly SRS
DE	Dual-Eligible
DENC	Detailed Explanation of Non-coverage
DES	Diethylstilbestrol
DFC	Dialysis Facility Compare
DHHS	Department of Health & Human Services
DI	Disability Insurance
DME	Durable medical equipment
DME-MAC	Durable Medical Equipment-Medicare Administrative Contractor
DMEPOS	Durable Medicare Equipment Prosthetics, Orthotics and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DOB	Date of Birth
DOD	Date of Death
DOE	Date of Entitlement
DoD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DOS	Date of Service

E

EGHP	Employer Group Health Plan
EOB	Explanation of Benefits
EOC	Evidence of Coverage
EOMB	Explanation of Medicare Benefits (replaced by MSN)
ERISA	Employee Retirement Income Security Act (of 1974)
ESRD	End-stage renal disease

F

FAQ	Frequently Asked Questions
FBDE	Full Benefit Dual-Eligible
FDA	Food and Drug Administration
FEHBP	Federal Employee Health Benefits Program
FFS	fee-for-service
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FMAP	Federal Medical Assistance Percentage
FPL	Federal poverty level
FPS	Fraud Prevention System
FR	Federal Register
FY	Fiscal year

G

GAO	Government Accountability Office
GEP	General Enrollment Period (1/1 – 3/31 – each year)
GHP	Group Health Plan

H

HBV	Hepatitis B Virus
HCBS	Home and Community Based Services
HCBWP	Home and Community Based Waiver Program
HCFA	Health Care Financing Administration (now CMS)
HCV	Hepatitis C Virus
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS (DHHS)	Department of Health and Human Services
HIC	Health insurance claim
HICN	Health insurance claim number (Medicare number)
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIV	Health Care Fraud Prevention and Enforcement Action Team
HMO	Health maintenance organization
HMO-POS	HMO Point-of-Service
HPV	Human Papillomavirus
HSA	Health Savings Accounts

I

IADL	Instrumental Activities of Daily Living
ICFs/MR	Intermediate care facilities for the mentally retarded
IDE	Investigational Device Exemption
IEP	Initial enrollment period
IHS	Indian Health Service
IPPE	Initial Preventive Physical Examination
IRE	Independent review entity
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
I/T/U	Indian Tribes and Tribal organizations, and urban Indian organizations

IVR	Interactive Voice Response
K	
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
L	
LEP	Late Enrollment Penalty
LIS	Low-income subsidy
LMB	Low-income Medicare beneficiary (KS-same as SLMB at Fed level)
L-OEP	Limited Open Enrollment Period
LPI	Low Performance Icon
LRD	Lifetime Reserve Days
LTC	Long-term care
LTCF	Long-term care facility
LTR	Lifetime Reserve
LTSS	
M	
M&M	Medicare and Medicaid
MA	Medicare Advantage
MAGI	Modified Adjusted Gross Income
MA-PD	Medicare Advantage with prescription drug plan
MAC	Medicare Administrative Contractor
MAC	Medicare Appeals Council
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAO	Medicare Advantage organizations
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MI	Medical Insurance (Medicare Part B)
MICs	Medicaid Integrity Contractors
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act (of 2003)
MMG	Medicare Marketing Guidelines
MNT	Medical Nutrition Therapy
MOON	Medicare Outpatient Observation Notice
MRI	Magnetic Resonance Imaging
MSA	Medicare Medical Savings Accounts
MSN	Medicare Summary Notice
MSP	Medicare Savings Program
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
MTM	Medication Therapy Management
N	
NAIC	National Association of Insurance Commissioners
NBI	National Benefit Integrity
NCC	National Coordinating Center

NCD	National Coverage Decision
NET	Newly Eligible Transition
NF	Nursing Facility
NIA	National Institute on Aging
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NOMNC	Notice of Medicare Non-coverage
NPA	National PACE Association
NPI	National Provider Identifier
NTP	National Training Program

O

O&E	Outreach and Education
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights
OEP	Open enrollment period
OEPI	Open enrollment period for institutionalized individuals
OIG	Office of the Inspector General
OOP	Out-of-Pocket
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
OT	Occupational Therapy

P

PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PAP	Patient Assistance Program
PBA	Pharmacy benefit administrator
PBM's	Pharmacy benefit managers
PDP	Medicare stand-alone prescription drug plan
PFFS	Private fee-for-service plan
PHI	Protected health information
PhRMA	Pharmaceutical Manufacturers and Researchers of America
POC	Plan of Care
POS	Point-of-Sale
PPACA	Patient Protection and Affordable Care Act 2010
PPO	Preferred provider organization
PPS	Prospective Payment System
PRO	Peer Review Organization (renamed QIO)
PSA	Prostate-specific antigen
PSO	Provider-sponsored organization
PT	Physical Therapy

Q

Q&A	Questions and Answers
----------------	-----------------------

QAPI	Quality Assessment & Performance Improvement
QDWI	Qualified disabled and working individual
QHP	Qualified Health Plans
QI	Qualified Individuals
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare beneficiaries
QWDI	Qualified Working Disabled Individual (aka QDWI)
R	
RAC	Recovery Audit Contractor
RDF	Renal Dialysis Facility
REACH	Regional Education About Choices in Health
RFI	Request for Information
RHC	Rural Health Center
RHHI	Regional Home Health Intermediary
RNHCI	Religious Non Medicare Health Care Institution
RO	Regional Office
RRB	Railroad Retirement Board
S	
SCE	Subsidy-Changing Event
SEP	Special Enrollment Period
SGS	SafeGuard Services, LLC
SHI	Supplemental Health Insurance
SHICK	Senior Health Insurance Counseling for Kansas
SHIP	State Health Insurance Assistance Programs (SHICK)
SHOP	Small Business Health Options Program
SLMB	Special Low-Income Medicare Beneficiaries (Federal, same as LMB in KS)
SME	Subject Matter Expert
SMI	Supplemental Medical Insurance (Medicare Part B)
SMP	Senior Medicare Patrol
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SOW	Scope of Work
SPAP	State Pharmaceutical Assistance Program (NOT available in KS)
SS	Social Security
SSA	Social Security Act
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SSN	Social Security Number
STI	Sexually transmitted infections
T	
TBD	To Be Determined
TDD	Telecommunications Device for the Deaf
TEFT	Testing Experience and Functional Assessment Tools

TFL	TRICARE for Life
Title I	Grants to State for old age assistance & medical assistance for the aged
Title II	Federal old age, survivors & disability insurance benefits (OASDI)
Title IV	Grants to States for aid & services to needy families with children (TAF)
Title X	Grants to State for aid to the blind (AB)
Title XIV	Grants to States for aid to the permanently & totally disabled (DI)
Title XIX	Grants to States for medical assistance programs (Medicaid)
Title XVI	Grants to States for aid to the aged, blind & disabled (ABD) & Supplemental Security Income (SSI)
Title XVIII	Health Insurance (Medicare)
Title XX	State operated home health care entitlement program
Title XXI	State Child Health Programs
TrOOP	True Out-of-Pocket
TTY	Text Telephones
TWWIA	Ticket to Work & Work Incentives Act (of 1999)
U	
U&C	Usual & customary
V	
VA (DVA)	Department of Veterans Affairs
W	
WCMSA	Workers' Compensation Medicare Set-Aide Arrangement
WPS	Wisconsin Physician Services
X	
XIXED	Title 19 Entitlement Date
Y	
YOB	Year of Birth
YTD	Year to Date
YYYY	Year
Z	
ZPIC	Zone Program Integrity Contractor

Medicare Prescription Drug Coverage Worksheet

1. What is your name as it appears on your Medicare card? ①

2. What is your Medicare Claim Number? ②

3. What is your date of birth?

Month/Date/Year

4. What is the effective date for your Medicare?

③ Part A _____
Month/Date/Year

④ Part B _____
Month/Date/Year

5. What is your Zip Code? _____

County? _____

Address, City, State _____

Phone # _____

*Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.

6. Check the **ONE** box that best describes your **INCOME**.*

Single, widowed, divorced or live apart from my spouse and:	Married and:
<input type="checkbox"/> My annual gross income is less than \$18,090	<input type="checkbox"/> Our annual gross income is less than \$24,360
<input type="checkbox"/> My annual gross income is greater than \$18,090	<input type="checkbox"/> Our annual gross income is greater than \$24,360

7. Check the **ONE** box that best describes your **LIQUID ASSETS**. Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions.*

Single, widowed, divorced or live apart from my spouse and:	Married and:
<input type="checkbox"/> My assets are \$14,100 or less	<input type="checkbox"/> Our assets are \$28,150 or less
<input type="checkbox"/> My assets are greater than \$14,100	<input type="checkbox"/> Our assets are greater than \$28,150

8. List the pharmacy or pharmacies you use. (Required)



9. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

DRUG NAME	DOSAGE	30- DAY QUANTITY	MONTHLY COST

SHICK Disclaimer

SHICK Counselor Name: _____ Telephone: _____

I have reviewed a minimum of three Medicare Part D Prescription Drug Plans and have chosen the following plan: _____. I give the SHICK Counselor listed above my authorization to enroll me in the above plan using the information I have provided. I confirm that all information provided is truthful and accurate and I hereby release the SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D enrollment herein. I also acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug plan until the next open enrollment period which will be October 15, 20__ to December 7, 20__.

I also understand the costs and covered medications quoted on the plan I've chosen may be subject to change.

Signature: _____ Printed Name: _____

Date: _____ Drug List ID: _____ Password Date: _____

Chapter 15

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